South West Local Health Integration Network
Annual Report 2015-2016

Ontario
South West Local Health Integration Network

Contents

Preface 3
Message from Board Chair and Chief Executive Officer 4
Board of Directors 5
The South West LHIN 6
Population profile 7
Community Engagement 10
Integrated Health Service Plan 2013-2016 15
Integration Activities 16
Update on South West LHIN Initiatives in 2015/16 20
- Health Links 20
- Emergency wait times and Alternate Level of Care pressures 20
- Home and community services investments that better support seniors and other Ontarians 22
- Mental Health and Addiction Services 23
- eHealth 29
- Health System Funding Reform 32
- Wait Times for surgical and diagnostic imaging procedures 32
- Diabetes Program Update 33

Local Health System Performance 35
Operational Performance 38
Financial Statements of the South West LHIN 41

Preface

Local Health Integration Networks (LHINs) have built a strong foundation of transparency, performance and accountability, striving to ensure that health care dollars are spent efficiently and effectively, yielding the best results possible. This is achieved through our mandated responsibilities related to planning, integration, and funding of health service providers in the local health care system.

LHINs operate within an accountability framework comprised of the *Local Health System Integration Act*, the Memorandum of Understanding between the Minister of Health and Long-Term Care and the South West LHIN, as well as the *Ministry-LHIN Accountability Agreement*.

As part of this accountability framework, LHINs must develop an Annual Report detailing progress and achievements made in the previous fiscal year. In addition to including specific requirements outlined in the key framework documents, the Annual Report contains audited financial statements for the organization.

This Annual Report outlines progress and milestones achieved in 2015/16. The Ministry of Health and Long-Term Care must table the Annual Report with the Legislative Assembly within 60 days of receipt. The Annual Report 2015-2016 will then be shared publicly once the Minister tables it in the Legislature.

Message from Jeff Low, Board Chair and Michael Barrett, Chief Executive Officer

This past fiscal year marked the final year in implementing our Integrated Health Service Plan (IHSP) for 2013-16 that guides us not only in achieving the vision outlined in our *Health System Design Blueprint: Vision 2022,* but also in working with local system partners and our provincial partners to move health system renewal forward. Each Integrated Health Service Plan, or IHSP, has built on the accomplishments of previous plans and has brought us closer to achieving the LHIN's vision for quality care, improved health and better value.

This Annual Report highlights and defines all the actions the LHIN, in partnership with health service providers, took in 2015/16 to enhance health care delivery for all residents of our LHIN.

In 2015/16, we made great progress in the strategic directions we set out to achieve in this last IHSP. There are fewer revisits to the Emergency Department within seven days of being discharged. Patients have spent more days at home – instead of in the hospital – because they received more appropriate care in other settings that better meet their needs. As well, more people were seen by their family health care provider within seven days of discharge.

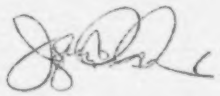
Much of 2015 was spent preparing for our IHSP for 2016-19. After listening to patients, caregivers, health service providers and members of the public, we designed a plan that is intended to reflect the needs and future directions of the health system. We know there is more work to do.

The provincial government put forward some bold ideas as part of their vision to put patients first. Leading up to and following the release of the *Patients First: A Proposal to Strengthen Patient-Centred Health Care* discussion paper in December 2015, the South West LHIN engaged primary health care professionals, health service providers, and members of the public to obtain feedback on what was outlined in the discussion paper.

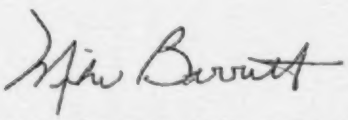
Community engagement is central to the work and management of the South West LHIN. Last year we engaged more than 1,200 people on all aspects of the LHIN. This contributes to building a system that better understands and meets the needs of people across our geography.

The South West LHIN Board continues to meet regularly with health service provider governors and our communities to promote integration, service coordination and quality improvement. We also continue to build our online relationships with valued partners and community members using social tools to foster dialogue, transparency and accountability.

In working with the Ministry of Health and Long-Term Care and health service providers, we remain committed to enhancing health care delivery for residents within the South West LHIN and throughout Ontario.



Jeff Low, Board Chair, South West LHIN



Michael Barrett, CEO, South West LHIN

Board of Directors

As of March 31, 2016

Jeff Low (London)
Chair
Feb. 7, 2011 - Feb. 6, 2017

Ron Bolton (St. Marys)
Vice Chair
May 12, 2010 - May 11, 2016

Lori Van Opstal (Tillsonburg)
Vice Chair
Nov. 6, 2013 - Nov. 5, 2016

Andrew Chunilall (London)
April 11, 2013 - April 9, 2019

Ron Lipsett (Annan)
July 28, 2010 - July 27, 2016

Wilf Riecker (Port Stanley)
Nov. 6, 2013 - Nov. 5, 2016

Barbara West-Bartley (Wiarton)
April 18, 2011 - April 17, 2017

Aniko Varpalotai (Southwold)
Oct. 3, 2012 - Oct. 2, 2018

One vacancy

The South West LHIN

The South West LHIN is responsible for the planning, integration and funding of 150 health service providers including: hospitals, long-term care homes, mental health and addictions agencies, community support services, community health centres, and the South West Community Care Access Centre.

Established in 2005, the South West LHIN covers a mixed rural and urban geography that ranges from Lake Erie to the Bruce Peninsula. By working together with all of our health service providers as a system of care – we ensure people receive the highest quality of care in the right place at the right time.

A high-performing health system improves people's health care experiences and ensures people receive timely, quality care with the best possible outcomes. It must also ensure the highest value for the money invested. To achieve these priorities and goals, all LHINs produce a three-year plan for the local health system that describes the vision, priorities, strategies and proposed outcomes. The plan, called the Integrated Health Service Plan (IHSP), identifies strategic directions and steps to make our overall vision of an improved health system a reality.

For the vast majority of people who require health care support, they receive it in their home community. Whether it is in-home care from a personal support worker, nurse or other health care professional, or an adult day program for individuals with dementia; community services are the key to the future sustainability of the health system. They allow for earlier discharge from hospitals, prevent re-admissions, and help delay or avoid admission to long-term care homes.

Hospitals in the LHIN provide care for those whose needs are beyond the services of a general practitioner, and our long-term care homes are there for those who can no longer live independently in their homes.

The following LHIN-funded organizations play a critical role in delivering services to South West LHIN residents:

- 78 long-term care homes
- 60 community support services
- 36 mental health and addictions agencies
- 20 hospital corporations across 33 sites
- 5 community health centres
- 1 Community Care Access Centre

There are also a number of organizations and professionals that, while they are not funded by the LHIN, play a crucial role in the delivery of health care services including family health teams, family health organizations, family health networks, solo-physician offices, public health units, emergency medical services and labs. While these services do not have direct accountability to the LHIN, it is essential to work closely with them to achieve our health system goals.

Population profile

Understanding the South West LHIN's population demographics and health status as well as the ability of the health system to meet population needs, plays a key role in improving population health, experience of care and value for money.

As part of developing each IHSP, the 14 LHINs worked with the Health Analytics Branch of the Ministry of Health and Long Term Care to create a detailed summary of demographic, population health and health system indicators for all LHINs. Unless otherwise indicated, the information below was taken from the provincial environmental scan used to develop the IHSP for 2016-19.

The South West LHIN is home to approximately 971,500 people, or 7 per cent of the Ontario population. London is the largest urban centre in the LHIN. It is home to 40 per cent of residents with a population of just over 366,000. Almost 30 per cent of the LHIN population live in a rural area and just more than 30 per cent live in small or medium communities.

Projections for the LHIN suggest that population growth will be slower than Ontario as a whole. Between 2015 and 2020 the LHIN's population is projected to grow by about 2.9 per cent, compared to 5.3 per cent for the province overall.

In 2015, seniors accounted for just more than 18 per cent of the LHIN's population, compared to 16 per cent in 2010. By 2021, 20.5 per cent of the population will be aged 65 years or older. The LHIN continues to have a higher proportion of adults aged 65 years or older than the province where 16 per cent of adults are aged 65 or older.

In 2011, approximately 86 per cent of the LHIN's population reported English as their first language. While 14 per cent of the LHIN's population were immigrants in 2011, fewer than 2 per cent were recent immigrants (arriving in Canada between 2006 and 2011).

According to 2011 census data, Francophones account for 1.5 per cent of the LHIN population, however an increasing number of Francophone immigrants are choosing London as their new home. London is also a designated area under the *French Language Services Act* and is home to approximately 8,000 Francophones.

The LHIN is home to five First Nations communities: three in the south and two in the north.[1] There is also a significant off-reserve Indigenous population. The LHIN is working with Indigenous populations to improve the quality of demographic data as it is recognized that Indigenous populations tend to be underrepresented in census data.[2] With this in mind, people who identify as Indigenous (First Nation, Inuit and Metis) account for 2 per cent of the LHIN population. In addition, the LHIN is home to Indigenous health services including the Southwest Ontario Aboriginal Health Access Centre (SOAHAC) with three locations, and two Friendship Centres.

---

[1] Chippewas of Nawash Unceded First Nation, Saugeen First Nation, Munsee-Delaware Nation, Chippewas of the Thames First Nation, Oneida Nation of the Thames

[2] "Census data limitations for Aboriginal populations include: Undercounting (homeless and mobility), non-participation is common (lack of trust), on-reserve enumeration is incomplete, weakened platform for self-identification (long form to voluntary NHS), data suppression, aggregate data, no data for children." Well Living House - Indigenous population health data collection, management, analysis and use, 2015

Socioeconomic characteristics

The median household income in the South West LHIN is $60,037, with 30 per cent of the total population living under the low-income cut-off. Levels of low educational attainment in the South West LHIN are above the Ontario average.

	South West	Ontario
Unemployment Rate (age 15+)	7.6%	8.3%
Education Attainment (age 25-64):		
• Population with no certificate/degree/diploma	13.2%	11.0%
• Population with completed post-secondary education	59.4%	64.8%
Population living below the low-income cut-off	30.0%	25.5%

2011 Canada Census

General health

Asking people what they think about their own health is an important way to monitor health status, in part because self-reported health status is a strong predictor of premature death and future disability.[3] [4] Six out of 10 residents say they have very good or excellent health, and seven out of 10 reported very good or excellent mental health. Also, 51 per cent of those aged 75 years or older still report very good/excellent health. Approximately 14 per cent of LHIN residents say they usually experience moderate or severe pain/discomfort, and 26 per cent say they experience activity limitations because of long-term physical or mental health problems. A total of 93 per cent of LHIN residents report having a regular medical doctor (similar to the provincial average).

Life expectancy and leading causes of death

The population residing within the South West LHIN has a lower life expectancy at birth and at age 65 compared to Ontario.[5] Ischemic heart disease, dementia and Alzheimer's disease, lung cancer, cerebrovascular diseases (stroke), and chronic lower respiratory diseases (pneumonia, chronic obstructive pulmonary disease) are the leading causes of death.[6]

Risk factors

	South West	Ontario
Active smoking in the last 12 months	17.9%	18%
Heavy drinkers	21.5%	17.2%%
Overweight or obese	59.9%	53.5%
Physically inactive	46.6%	45.6%
Inadequate consumption of fruits and vegetables (consuming fewer than 5 servings daily)	60.3%	60.8%

[3] DeSalvo, K.B., et al., Mortality Prediction with a Single General Self-Rated Health Question. Journal of General Internal medicine,2006.21: p.267–275.

[4] Idler, E.L. and S.V.Kasl, Self-ratings of health: Do they also predict change in functional ability? The Journals of Gerontology Series B: Psychological Sciences and Social Sciences. 1995.50B (6): p. S344-53.

[5] Table 102-4307 Life expectancy, at birth and at age 65, by sex, three-year average, Canada, provinces, territories, health regions and peer groups, occasional (2007-2009), Statistics Canada,

[6] Vital Statistics Registry 2011, Ontario Ministry of Health and Long Term Care.

Chronic disease

Approximately 39 per cent of LHIN residents (aged 12 years or older) have a chronic condition, and 16 per cent have multiple chronic conditions. The prevalence of multiple chronic conditions increases with age. The LHIN had higher mortality rates and more average time spent in acute care as an admitted patient than the province for all conditions except asthma. Compared with the province, the LHIN had the highest number of acute hospital care discharges per person for all chronic conditions except ischemic heart disease and asthma.

Prevalence of chronic conditions in the South West LHIN *Rate per 100 people, 2013 (age 12+)*	South West	Ontario
Arthritis (age 14+)	20.6	17.3
Asthma	9	7.5
Cancer	1	1.9
Chronic obstructive pulmonary disease (age 35+)	4.8	4.3
Diabetes	7	6.6
High blood pressure	17.5	18.3
Heart disease	4.7	4.8
	39	37.3
	15.6	15

Canadian Community Health Survey LHINS Sharefile (CCHS), 2013/14

Accessing primary care

There are approximately 600 primary care physicians actively practicing in community settings in the LHIN – more than 400 of these physicians practice as part of the 90 primary care groups (e.g. family health networks, family health organizations, etc.) in the LHIN. There are 290 primary care physicians practicing as part of the 19 multi-disciplinary family health teams across the LHIN. More than 90 per cent of LHIN residents have access to a primary care provider. Health Care Connect is a service that allows people to find a family physician. Between its launch in February 2009 and May 2015, 44,722 LHIN residents have registered with the program and 95.7 per cent have been referred to a family health service provider.[7]

Physicians

Between 2010 and 2013, the total number of physicians in the LHIN had increased by 8.7 per cent reaching a total of just more than 2,000. The physician-to-population rate in the LHIN increased to 212.1 physicians per 100,000 people in 2013 (from 196.9 in 2010). The family physicians-to-population rate in South West (92.8 per 100,000) was slightly higher than the province's rate (83.2 per 100,000 population) in 2013.

Nurses

Between 2011 and 2014, the total number of nurses in the LHIN increased by 3.4 per cent reaching a total of 13,924 (from 11,901 in 2010) while the nurse-to-population rate increased to 1,440.1 nurses per 100,000 people (from 1,249.8 nurses per 100,000 people in 2010). Compared to the province, in 2014 the LHIN had a higher number of registered nurses, registered practical nurses and nurse practitioners rates per 100,000 people. The number of nurse practitioners in the LHIN increased by 28 between 2011 and 2014 for a total of 227 in 2014.

[7] Health Care Connects monthly report to the LHIN, June 2015

Community Engagement

The Communications and Community Engagement plan for 2015/16 outlined how the LHIN would achieve its communications objectives and priorities for the fiscal year. It considered all audiences and guided the development of all communications plans and activities throughout 2015/16.

LHIN communications and engagements are designed to build momentum for lasting change and bring the LHIN, health service providers, health care partners such as physicians and other key stakeholders (eg. Public Health) as well as the Ministry of Health and Long-Term Care together to focus on clear messaging, common themes, reputation building and bringing timely information to stakeholders and the public. It is a shared responsibility where we must lead collaboratively to promote our common goals and values.

The LHIN used a variety of strategies to inform, consult, involve and collaborate with stakeholders so that communities continue to be engaged on the actions that the LHIN, in partnership with health service providers, is taking to enhance health care delivery for all residents of our LHIN.

The South West LHIN Communications and Community Engagement Plan, as well as the IHSP for 2013-16 and the Annual Business Plan guided our engagement approach.

Throughout 2015/16, we were involved in a broad range of engagement activities including:

- Regularly scheduled advisory committee meetings
- Regular meetings with area provider tables
- Sector and network meetings
- Project and program-specific meetings
- Health System Funding Reform Local Partnership
- Health System Leadership Council
- Integrated Health Service Plan sessions
- The annual Quality Symposium
- Physician Engagements
- Local health and information networking sessions
- Engagement with Francophone and Indigenous communities

Integrated Health Service Plan sessions

The IHSP is intended to represents the voices of the diverse populations who use our health care system including Indigenous and Francophone populations as well as the health service providers that work every day to meet the needs of the people they serve.

To gain valuable feedback on the draft IHSP plan for 2016-19, eight sessions were held in Middlesex Centre, St. Thomas, Woodstock, Owen Sound, Kincardine, London, Mitchell and Clinton. Attendance rates were 40 per cent higher per event than in previous IHSP engagements.

At the end of each session, participants were invited to provide feedback on the session format and overall information provided.

- 96% felt the information shared was Good/Excellent
- 94% felt the format of the session was Good/Excellent
- 94% felt their overall satisfaction for the session was Good/Excellent
- 87% learned something new
- 97% felt they had an opportunity to ask questions and discuss important issues.
- 94% felt their time was well spent

Quality Symposium

The annual Quality Symposium was held on June 4, 2015 in Stratford, Ontario. The event was attended by 379 people representing a broad range of sectors.

The theme was "Partners in Quality: Working Together to Transform the Health System." Presenters included journalist and author Jeffrey Simpson, Dr. Jeffrey Turnbull, and Canadian mental health advocate Mark Henick.

Quality Awards were handed out to two local projects to recognize sustainable and ongoing quality improvement initiatives:

- The award for Population Based Integrated Health Services Delivery went to the Connecting Care Collaborative. Partner organizations include St. Joseph's Health Care London, London Health Sciences Centre, and the South West Community Care Access Centre (CCAC).
- The Centrally Coordinated Resource Capacity award was given to the Southwestern Ontario Stroke Network Stroke Capacity Assessment and Best Practice Implementation Project. Partners of the project include the Southwestern Ontario Stroke Network, all hospitals providing stroke care in the South West LHIN, Emergency Medical Services and the South West CCAC.

The event was very well received, with 99 per cent of evaluations indicating they enjoyed the event, and 90 per cent stating they know more about key quality strategies and initiatives.

Physician engagements

As part of ongoing dialogue with physicians, the LHIN held five physician engagements in November and December 2015 to discuss the future of primary health care in the South West LHIN. These sessions were held in partnership with the Ontario Medical Association and the Ontario College of Family Physicians. More than 200 physicians and primary health care providers met across our five sub-region areas to participate in world-café style dialogue and discussion. Feedback was posted to our website and helped drive the direction of our future engagements.

The South West Primary Care Network in partnership with the South West Community Care Access Centre, Ontario College of Family Physicians, Ontario Medical Association, South West Regional Cancer Program, and the South West LHIN also hosted a one-day Primary Care Congress in April 2015. The engagement saw an 18.5 per cent increase in attendance over the previous year.

Local health and information networking sessions

In 2015, sessions were held in Owen Sound (May 2015), Woodstock (September 2015) and Zurich (November 2015). With a 6.5 per cent increase in attendees per session over the previous year, sessions were open to governance, partners and the public. Topics ranged from integration activities to Patients First discussion paper feedback and information sessions.

Participants expressed an increase in value of engagement:

- More liked the format: 98% felt the format was Good/Excellent vs. 90% in 2014-15
- More were satisfied: 97% felt the session was Good/Excellent vs. 87% in 2014-15
- Fewer learned something new: 89% vs. 91% in 2014-15
- More felt they could ask questions and discuss issues: 100% vs. 97% in 2014-15
- More felt their time was well spent: 98% vs. 94% in 2014-15

Long-Term Care Home Network Forum

On September 21, 2015, the South West Long-Term Care Homes Network Council brought together 81 local long-term care providers in Stratford for the second annual Long-Term Care Home Network Forum. The forum featured speakers from Behavioural Supports Ontario, PeopleCare in Stratford, the South West Community Care Access Centre, Ontario Long Term Care Association, the Ontario Association of Non-Profit Homes and Services for Seniors, the Ministry of Health

and Long Term Care, and long-term care providers from the South West area.

French engagement

The South West LHIN remains committed to improving access to health care services in French and improving the health outcomes and experience of the Francophone population in our LHIN. Throughout the 2015/16 fiscal year, several community engagement and planning initiatives were undertaken to better understand and address the health care challenges faced by Francophones in the South West LHIN.

The South West LHIN continued its collaboration with the French Language Health Planning Entity in the South West, where regular meetings are held to discuss progress on the joint action plan and collaborative planning for community engagement activities. The French Language Liaison Committee, with representation from the Erie St. Clair and South West LHINs and the Erie St. Clair/South West French Language Health Planning Entity, continued its work. This group meets and works on the deliverables from the joint action plan to support better health care services for local Francophone residents. The South West LHIN French Language Services Coordinator continued active participation in many French language focused committees, working groups, and in the planning of community events.

Key community engagement and planning initiatives included:

- Community engagement with stakeholders, community representatives and populations using surveys, sessions, and focus groups (Francophone seniors group, mental health and addictions advisory group, Table de concertation francophone de London-French Networking Table, French Language Health Planning Entity's Board of Directors).
- Active participation with the Addictions Services of Thames Valley French Mental Health and Addictions Advisory committee.
- Some of the topics francophone were engaged on were the 2016-19 Integrated Health Service Plan, Ministry of Health and Long Term Care: Patient's First Discussion Paper, Home and Community Care and Understanding Health Inequities and Access to Primary Care in the South West LHIN.
- Efforts continue to introduce and distribute the French Language Services Toolkit to Health Service Providers, different groups, and committees in our region to support our providers to implement French-language services.
- A French Language Services information and resources booth was set up in collaboration with the healthline.ca at the 2015 Quality Symposium to engage and inform health professionals on the francophone population profile of the region and to provide resources, signage and identification badges to promote an active offer of French Language.
- Participated in writing the health insert in a special edition of Bonjour Ontario – L'Action (French newspaper) to share information on French services offered in our region.
- Celebrated 400 years of francophone presence in Ontario by participating in different commemorative events and articles.
- Assisted promotion and planning of health promotion activities such as falls prevention, exercise classes, and living with diabetes.
- Health Equity Impact Assessment work was completed in coordination with Health Links, Behavioural Supports Ontario, and Palliative Care.

Indigenous community engagement

Across the LHINs, meaningful Indigenous community engagement is critical to understanding and responding to the health needs of diverse Indigenous peoples. By working in partnership with the Indigenous community and involving Indigenous people in the planning process, we are able to enhance the quality of care and patient experience for those most vulnerable and in need of health care services.

The South West LHIN engages the Indigenous community formally through the *South West LHIN Aboriginal Health Committee*, comprised of Indigenous representatives from First Nations communities, Indigenous organizations and health service providers located across the

region. The Committee advises the LHIN directly on Indigenous health issues, integration and partnership opportunities.

Key engagement activities and program initiatives:

- The adoption of Indigenous Cultural Safety training by health service providers continues to grow across the South West LHIN. Launched in May of 2014, this initiative has the capacity to train 1,200 health care providers every year in our region. The training is a unique, facilitated on-line training program designed to increase knowledge, enhance self-awareness, and strengthen the skills of those who work both directly and indirectly with Indigenous peoples and communities. The goal of ICS is to develop and promote individual competencies and positive partnerships with Indigenous patients, families and communities.
- In support of both the Health Links and Primary Care Capacity Steering Committees, The South West LHIN Aboriginal Health Committee developed a series of recommendations based on four completed data reports on Indigenous health over the past two years. 15 of the 28 recommendations have been embraced for local Health Links implementation, and others are being circulated for inclusion at various planning tables and portfolios across the LHIN.
- In 2016, Indigenous communities and health service providers received toolkits to distribute to residents on asthma education and awareness in Indigenous communities called "Breathe Easy". The toolkit was developed by the Asthma Society of Canada, and re-designed to meet the needs of communities in this region in partnership with the South West LHIN, Southwest Ontario Aboriginal Health Access Centre, and the South West LHIN Aboriginal Health Committee.
- As part of the Aboriginal roadmap to advance Indigenous-informed pathways to hospice palliative care developed in 2014-2015, the South West LHIN has partnered with an Indigenous researcher to undertake a two-year project to develop a readiness and needs assessment for community-based hospice palliative care teams in local First Nations. This work is based on the End of Life in First Nations report and workbook developed at Lakehead University and piloted in four First nations across Ontario.
- Engagement with CCAC to identify training and engagement opportunities to address a more integrated and supportive approach home and community care in partnership with federally-funded services in First Nations.
- Bi-monthly, face-to-face South West Aboriginal Health Committee meetings
- Coordination and participation in a pan-LHIN Aboriginal network to support the advancement of a system wide strategic approach for Indigenous health planning and engagement.

Shared Accountability Sessions

Health service providers from each sector were invited to participate in one of five South West LHIN's "Impacting system improvement through Service Accountability Agreements: Shaping the South West's Future Direction" engagement sessions, held between September 30 and October 21, 2015. These sessions aimed to advance shared accountability and cross-sector collaboration to increase care in the community and strengthen mental health and addiction services.

Approximately 250 people who participated in session engagement exercises were asked "what does sector X need from sector Y" and a number of common enabling themes emerged. From sector-specific discussions, ideas were discussed for inclusion as potential local performance expectations in the 2016/17 cycle of Service Accountability Agreements (SAAs).

Though the goal of the engagement sessions was to focus on modernizing how the LHIN uses SAAs to advance shared accountability for improved outcomes, session participants surfaced a number of related or contextual issues. These broader system challenges required further discussion, triaging, and planning between the LHIN and system partners to action, but a number were identified as aligning to the priorities and initiatives outlined in the LHIN's Integrated Health Services Plan for 2016-19.

Through the course of the SAA engagement discussions, regional strengths and opportunities to move closer toward shared accountability were observed, along with innovative quality improvement ideas. Using shared learnings and best practices from these discussions, participants were encouraged to consider these ideas and how to include in their organization's quality improvement planning.

Integrated Health Service Plan 2013-2016

Improving people's health care experiences and ensuring people receive timely, quality care with the best possible outcomes is what defines a high-performing health system. We also need to ensure that we get value for the money invested. To achieve these priorities and goals, we have developed an Integrated Health Service Plan (IHSP) for 2013-2016 that outlines strategies and objectives to support people to live healthy, independently and safely at home.

The IHSP is a call-to-action for health service providers and their boards outlining numerous areas where collaboration among primary care partners, community-based care, long-term care and hospitals will be essential to ensure an optimal health care system.

The IHSP sets three goals:

1. Improve population health and wellness
2. Improve person experience with the health system
3. Improve sustainability of our health system

To meet these goals, we set out four strategic directions to guide progress:

- Improve access to family health care
- Improve coordination and transitions of care for those most dependent on health services
- Drive safety through evidence-based practice
- Increase the value of our health care system for the people we serve

To achieve these strategic directions we developed 16 program areas with 87 initiatives in total that continue to be implemented in collaboration with our health service providers.

The 16 program areas include:

- Access to Care
- Behavioural Supports Ontario
- Chronic Disease Prevention and Management
- Clinical Services Planning
- Connecting and Empowering People
- Critical Care
- Diagnostic Imaging
- Emergency Services
- Health Links
- Hospice Palliative Care
- Long-Term Care Home Redevelopment
- Mental Health and Addictions
- Quality and Value
- Safety
- Technology to Connect and Communicate
- Transportation Best Practices

In addition, there are three key drivers that enable the strategic directions and initiatives:

- Technology to connect and communicate
- Quality and value
- Connecting and empowering people

The 'big dots' are indicators that measure our system performance and include:

- Increasing availability of family health care
- Reducing 15,000 emergency room visits and hospital readmissions, resulting in 10,000 more days at home
- Increasing availability and access to community supports for people, resulting in 7,100 more days at home

Integration Activities

Many LHIN initiatives result in better integration of health services to benefit patients and families across the LHIN, however, integration activities may not always come forward as formal integrations and are captured elsewhere in the *Annual Report. Other integration activities that progressed in 2015/16 are as follows.*

Organizational assessments

The South West LHIN has designed a tool to create comprehensive assessments that could lead to service, administrative and governance integration activities, improving quality and accountability of services provided. The tool has been developed for health service providers – with Board and LHIN staff assistance – to assess an organization's health by scoring statements in four sections:

1. Organizational Health (governance, executive and strategic leadership)
2. Human Resources (staff and volunteers)
3. High Quality Health Services
4. Finance and Performance

In 2015/16, the LHIN completed testing of the process and tool with two health service providers (Canadian Mental Health Association Middlesex and Hutton House). The LHIN and participants worked through responses to each statement together - probing along the way to understand scores chosen by providers.

Participants reflected on and discussed: which statements worked well, what could be improved, the impact statements may have for other organizations, if the scoring made sense, if interpretations and recommendations needed changes (e.g. do these recommendations offer appropriate actions for consideration, including integration opportunities to mitigate the issues identified?).

The LHIN is currently revising the process and tool based on the learnings from the two pilots.

Joint Services Plan for Oxford County hospitals

With the opening of the new Woodstock General Hospital in November 2011, capacity was added to Oxford County and area. In order to ensure the additional capacity is utilized efficiently and effectively, the South West LHIN requested the 3 hospitals in Oxford County (Woodstock General Hospital, Tillsonburg & District Memorial Hospital, and Alexandra Hospital in Ingersoll) work collaboratively to develop a framework for a Joint Services Plan. The Joint Services Plan was completed in 2 phases:

Phase 1 (completed in 2014/15)

- Pharmacy Services – Recommendations implemented in 2014/15
- Surgical Services – Consolidation of endoscopy procedures at Tillsonburg District Memorial Hospital (TDMH) and Woodstock Hospital (WH), and consolidation of cataract procedures at Alexandra Hospital (AH) and WH completed in 2014/15
- Alternate Level of Care – Closure of 9 Complex Continuing Care (CCC) beds at AH and 6 CCC beds at TDMH in 2014/15

Phase 2 (completed in 2015/16)

- Laboratory Services – Lab service integration that will aid in eliminating the deficit and improving the delivery of lab services for the Oxford community
- Mental Health and Addictions – Collaborative model of care that will address identified gaps and better serve the Oxford County population
- Paediatrics and Children's Health Services – Collaborative model of care among a network of providers that would address identified gaps and better serve the population
- Continued research into different Governance Structures and a communications work stream to ensure

continued engagement and consistent messaging across all stakeholder groups

Access to Care: Complex continuing care / rehabilitation bed realignment

As part of the Access to Care strategy to help people move out of acute hospitals and into other care settings as quickly, smoothly and safely as possible, the Complex Continuing Care and Rehabilitation (CCC/Rehab) initiative will ensure that these valuable services are provided consistently and equitably across the region.

Phase 1 realignment was completed in 2015/16:

- Increased 10 CCC beds at Grey Bruce Health Services – Wiarton
- Increased 2 Rehab beds at St. Thomas Elgin General Hospital (STEGH)
- Decreased 15 CCC beds at STEGH
- Decreased 15 CCC beds in Oxford County (6 at Tillsonburg District Memorial Hospital, 9 at Alexandra Hospital Ingersoll)
- Ensured that the ongoing operating costs of changes to be implemented are cost neutral at the LHIN level

In order to arrive at Phase II recommendations, the CCC/Rehab Steering Committee refreshed the bed projection model used as one of the inputs for Phase I recommendations. Other inputs include a "system impact matrix" that will assist in finalizing recommendations. The system impact matrix incorporates elements such as Long-Term Care availability, implementation status of the Access to Care project and other quality initiatives.

Full implementation of the first stage of the Phase II realignment recommendations is awaiting finalization of the financial impact assessment. A "stage and gate" approach has been established to allow for ongoing review and analysis of impacts of implementation before moving to the next stage.

Future phases of realignment will be dependent on refreshing the projection model with more current data and information. Future data refreshes will include information gained through the Evidence Informed Bedded Rehabilitation Capacity Plan, the Rehabilitative Care Alliance Bedded Definitions Framework Project and impacts of the Stroke Phase I Realignment Recommendations.

This initiative will improve outcomes for patients and families, and for the health system as a whole. It will:

- Develop the CCAC role as the one point of access, so that patients/clients across the South West get the right care at the right time and place.
- Ensure that admission to CCC/Rehab beds is based on consistent assessment processes and criteria.
- Ultimately, this work will reduce wait times and improve utilization for CCC and rehab beds, and reduce the number of patients designated as ALC.
- The goal is to provide the right care in the right place at the right time, which, when combined with local strategies, is anticipated to reduce the volume of alternate level of care days in the long term and provide for the best possible outcomes for individuals and their families.

Huron Perth Healthcare Alliance – Vision 2013

Vision 2013 is a multifaceted plan to create a sustainable healthcare system now and into the future. The Vision 2013 planning process is based on four principles: Retain four sites with viable roles; Ensure standards of quality and safety; Support equitable standards of quality and patient safety for patients; Live within our means.

While implementation was expected to have been complete, work continues into 2016-17 as there are dependencies on CCC/Rehab shifts associated with Access to Care.

Anticipated impact is:

- Realignment of Services
    - Consolidation of adult outpatient physiotherapy from 4 sites to 2 sites completed in 2012 (Seaforth and Clinton sites).
    - Inter-professional practice model of care (implementation to be completed Dec. 2014).

- Consolidation of cataracts at Clinton site (May 2014).
- Bed Redistribution
  - Redistribute beds amongst the sites to better utilize capacity. Includes relocation of CCC and Rehab beds and shifts in the number of medical and surgical beds to result in a net decrease of 17 beds.

Back Office Collaboration and Integration Project

As we continue to work together to improve the experience of care of people who use health care services and ensure sustainability of those services, the South West LHIN continues to advance a number of integration strategies. One of those strategies is the Back Office Collaboration and Integration Project.

The purpose of the project is to use system resources effectively to achieve the highest quality back office services and create readiness for future health system transformation. The Back Office Collaboration and Integration Project is one of the LHIN's integration strategies intended to improve the experience of care of people who use health care services and ensure sustainability of those services.

Objectives

- More accuracy and reduced errors in reporting requirements
- More trust, transparency and effective communication among health service providers
- Meeting or exceeding established best practices within organizations and across sectors
- More business intelligence and decision-making at the health service provider level
- Streamlined processes and eliminated/reduced duplication

A Steering Committee provides oversight to the project, guides and leads change efforts, and fosters collaboration (both at the system-wide level and within targeted implementation initiatives.)

Phase 1

In 2015/16, the South West LHIN engaged a third party resource (Deloitte) to leverage expert resources and define best practices and minimum standards in the seven identified administrative service areas:

1. Financial Management
2. Information Technology and Support
3. Materials Management
4. Human Resources
5. Risk Management & Privacy
6. Legal Services
7. Facilities Management

The LHIN requested content expertise from each sector and sub-region to participate on sub-committees to assist in defining the leading practices and minimum standards in each of the 7 identified administrative areas.

Sub-committee workshops to review and validate the inventories of draft business processes per administrative area were completed in early February 2016. Edited inventories were distributed to the sub-committee members for additional feedback and sub-committees were then reconvened in early March 2016 for discussion on any final thoughts and/or points regarding the standards/implementation considerations from the sub-committee members.

Results

At their March 29 meeting, the Steering Committee reviewed and discussed the draft report. Suggested revisions to the report were incorporated, and the final report was received by the LHIN on March 31, 2016. The final report is available on the South West LHIN website.

368 identified Minimum Business Process Standards were validated within an Inventory of Business Process Practices across the seven administrative areas. The best practices and minimum standards include relevance and understanding to the Mental Health and Addictions, Hospital, Community Support Services, Community Care Access Centre, Community Health Centre and Long-Term Care Home sectors. Regardless of current practices, understanding what the practice is and how the LHIN may assist providers in achieving best practice is the goal.

The Steering Committee feedback on Phase 2 planning is being considered in alignment with health system transformation.

Reduction and redistribution of restorative care beds across Grey Bruce

In August 2015, the South West LHIN directed a review of restorative care across the Grey Bruce area. The LHIN provided one-time funding ($50,000) to acquire the services of an expert consultant to assist the organizations to develop a range of meaningful options for the review of restorative care services provided at the Chesley site of South Bruce Grey Health Centre (SBGHC). Deloitte was engaged to conduct the review which included:

- A review of current and planned RC services available in the area
- Development of 3-4 options for sustainable RC service delivery models for the Grey Bruce area that align with broader LHIN initiatives. Options were to be based on current state understanding, in combination with leading practices
- Engagement of a Project Working Group in a review of service delivery model options and associated implications
- Development of service delivery model recommendations to enable the Grey Bruce Health Network RC Working Group to prepare a submission to the South West LHIN

The Restorative Care Services Review Final Report was submitted on September 30, 2015. The following guiding principles informed the recommendations:

- Focus on patients: Service delivery models identified will ultimately enable better delivery of patient care and/or improve the capacity to deliver better patient care
- Optimization through leading practice: We will use evidence to inform development of the optimal service delivery model and incorporate leading practices where possible
- Consideration of the local communities: Service delivery models that are identified will consider the needs of and impacts to the local community and will be in line with regional priorities
- Financial sustainability: Service delivery models should enable and/or improve financial sustainability for the local health system

The final report outlined five options that were considered by the partners. Based on the analysis of the options, the organizations involved have agreed that the recommended model for RC services in Grey Bruce is to develop an integrated regional program of RC beds that will be distributed across the counties to provide patients with access to care closer to home.

This recommended model would be achieved by:

- Reducing the number of beds at Chesley from 10 to 5 beds
- Opening 2 to 3 RC beds at Hanover District Hospital
- Leveraging existing bedded capacity within Grey Bruce Health Services
- Promoting Home First and Community Care Access Centre (CCAC) services in the community

This model places emphasis on the regionalization of beds and coordinated intake through the South West CCAC. The South West CCAC will serve as a centralized access point for RC across the area. They will be responsible for assessing patients against established, standard admission criteria to determine eligibility for RC. The first step for all patients assessed by the CCAC will be to consider eligibility for home first:

- If patients are eligible for home first, they will be connected with the most appropriate home, community and social services to support their health needs in the community/home setting.
- If patients are eligible for RC, they will be admitted to one of approx..11-12 available regional beds (e.g. across Grey Bruce) coordinated through the CCAC.

Health Links

The Health Links approach intends to improve communication and collaboration among providers who share in the care of people with high care needs, typically those with four or more chronic/high cost conditions. Providers are encouraged to consider three specific populations: those with mental health and addictions challenges, those with palliative care needs, and frail seniors, many of whom experience challenges with the social determinants of health. Multiple providers, appointments and complex care issues can make it difficult to support these individuals.

A more collaborative approach to care can be achieved through a process called coordinated care planning. Coordinated care planning aims to bring local health and social service providers together, with patients and their families, to develop a care plan based on the individual's goals. This care plan allows for more coordination and faster follow-up when people transition from one provider to another, allowing people to live well in their communities and reduce avoidable health care utilization.

In the South West LHIN we have identified six geographies for the Health Links approach: North Grey Bruce, South Grey Bruce, Huron Perth, London Middlesex, Oxford and Elgin. Grey Bruce, Huron Perth and London Middlesex are actively working with individuals and their families to coordinate care to assist them in meeting their goals. All four of these geographies have exceeded the number of people that they were targeting to support, with a total of 265 residents having experienced the coordinated care planning process in 2015/16. Elgin and Oxford have completed their business plans, submitted these plans to the South West LHIN, and received approval from the LHIN in February 2016. As of April 2016, these two geographies are awaiting funding to implement the process of identifying people with high care needs, working with them to identify their goals, and collaboratively building coordinated care plans.

The Health Links Learning Collaborative is an action-oriented learning program to equip teams to make improvements in coordinated care delivery and achieve results. It has been developed as a staged program. Cohort 1 has had three sessions to date: March 2016, September 2015 and March 2015. A second cohort in the program attended their first learning session in March 2016.

Emergency wait times and Alternate Level of Care pressures

Improving Patient Access and Flow

Improving patient access and flow was identified as a key priority in the South West LHIN given
challenges that remain with access to inpatient beds in the London hospitals, and across the LHIN at key times during the year.

Under the leadership of the Chief Nursing Executive (CNE) Leadership Forum, the LHIN, Community Care Access Centre (CCAC), and all Hospital providers in the South West LHIN (including Bluewater Health in the Erie St. Clair LHIN), are working together to improve key drivers to patient access and flow.

In response to access challenges identified in previous holiday seasons, the following regional action plan was implemented for improving the 2015/16 Holiday Season (peak period):

- Capacity planning at individual organizations to understand staffing patterns and expected demand for bed availability over the holiday period
- Improved communication and collaborative planning regarding surgical/ambulatory slow-downs across the LHIN, and proactive planning related to coverage
- Daily regional bed huddles including participation from the LHIN and leaders from all hospitals and CCAC in

order to identify and resolve access issues that may have arisen during peak periods
- Engagement of key stakeholder groups and networks, and a communication strategy to inform patients and family of other options available during the holiday period

Moving forward, a 2-year plan has been established including the following longer term priorities.

Key enablers:
- Regional Access and Flow Dashboard –development of a comprehensive Regional Access and Flow Dashboard with the aim of ongoing monitoring of system performance.
- Access and Flow Memorandum of Understanding (MOU) and Policy/Protocol – review and evolve the existing Patient Access and Flow One Number Protocol including the development of a policy and/or protocols to support the access and flow work.

Four longer term priorities have also been identified as part of the longer-term strategy based on a comprehensive current state data review.

1. Mental Health Capacity Planning – leverage and collaborate on work currently underway as per previous discussions at the CEO Leadership Forum, including development of a surge protocol, and implementation of evidence based pathways and standards.
2. Alternate Level of Care (ALC) and Difficult to Serve – leverage initial investigative work currently underway to explore additional alternate level of care options in London Middlesex.
3. Surge Planning – development of a Holiday 2016/2017 work plan that includes more in depth consultation with community and primary care partners, and draws on lessons learned from other LHINs regarding avoidance strategies.
4. Long Term Care Homes (LTCH) / Hospitals Collaboration – working more collaboratively with LTCHs to improve relationships with the goal of working as a system to provide the right service at the right time by the most appropriate provider.

Partnering to improve Emergency Department wait times

High volume Emergency Department organizations in the South West LHIN have been working to improve patient wait times and overcrowding through development of Action Plans for improvement, and participation in a Learning Collaborative. Over the past year, participation has been expanded to include leaders from the Emergency Department and Inpatient Units, CCAC, Medical Advisory Committee, etc.

The approach also includes participation in the provincial Emergency Department Pay-for-Results program for eligible sites.

A key focus of our strategy is to improve Emergency Department wait times for admitted patients. Wait times for admitted patients have improved at many of the participating organizations since the start of the project. As of May 2016, compared to baseline established in 2012-13, substantial reductions were realized at the following hospital organizations:

P4R Organizations	Wait Time Admitted Pts (*hours*)		
	2012-13	YTD 2015	Progress
SouthWest LHIN	**23.8**	**20.2**	-15.1%
LHSC - UH	30.1	23.3	-22.6%
LHSC - VH	29.5	27	-8.5%
STEGH	7.7	7	-9.1%
GBHS-OS	9.1	9.2	1.1%
Woodstock	12	7.5	-37.5%

KT Organizations	Wait Time Admitted Pts (*hours*)		
	2012-13	YTD 2015	Progress
Stratford	16.4	11.9	-27.4%
Tillsonburg	24.6	21.4	-13.0%
Strathroy	10.3	10	-2.9%

Home and community services investments that better support seniors and other Ontarians

In 2015/16, the South West LHIN invested over $5 million in ongoing support for the community sector, including an 'across the board' increase for community health service providers (community support service, acquired brain injury, assisted living services-supportive housing, community health centres, and mental health and addictions health service providers). In addition, $4.5 million was invested in one-time funding for targeted investments:

- Improvements in coordination and transitions of care for people accessing community support services in Huron Perth through an integrated care model for coordinated care planning and common intake across all community support service partner agencies.
- Improved access to services for high needs seniors through the expansion of the Assisted Living Hub model across the LHIN, addressing unmet care needs for high needs clients including frail seniors and adults with disabilities.
- Increases in the number of frail people receiving intensive care support to go home to recuperate after a hospital stay.
- Increases in the number of people receiving stroke rehabilitation programming and exercise and falls prevention classes in the community.
- Enhanced crisis support for people living with addictions.
- Increased access to traditional healing services and improved coordination between traditional healing and conventional primary care providers.
- More resources available so that people can die in the place of their choice.

Seniors and Adults with Complex Needs

In 2015/16, the South West LHIN focused on advancing or bringing to completion several key projects aimed at improving care for seniors and adults with complex needs with the long-term goal of optimizing their health, being responsive to their changing needs and supporting safe and independent living in a fiscally responsible way.

Anchored in the province's Patients First: A Roadmap to Strengthen Home and Community Care, the LHIN began actively planning the work of implementing the policies related to the Expansion of Personal Support Services and the Community Care Access Centre (CCAC)-Community Support Services (CSS) Integration. The implementation of these policies will lead to a "one-sector" experience by clients. Standards that need to be met include: coordinated intake, screening and assessment, care and service planning, care coordination, shared information, service delivery and wait list management.

The model being worked on borrows heavily from the success of the Huron and Perth community support service network. Accomplishments to date include a shared information and technology platform, collaborative care coordination, and common intake among community support service agencies.

Improving integrated hospice palliative care continues to be a key focus area in the South West, with the aim of advancing a comprehensive and coordinated system of hospice palliative care services that meets peoples' needs. The South West Hospice Palliative Care (HPC) Network guides and informs the implementation of provincial commitments of HPC including: strengthening accountability and introducing mechanisms of shared accountability; improving integration and continuity across care settings; strengthening service capacity and human capital in all care settings; broadening access and increase timeliness of access, strengthening caregiver supports; and building public awareness.

The South West HPC Leadership committee continues to engage with health service providers, patients and families through its local HPC collaboratives to ensure people are receiving improved palliative care support in the South West. Much of 2015/16 was spent advancing quality improvement activities led by the local collaboratives and regional HPC capacity planning activities to help inform current and future planning.

Another important area of improvement is related to Access to Care work that continues to be an essential driver in supporting seniors and adults with complex needs in their homes for as long as possible, with community supports.

Supporting seniors and adults with complex needs through the Access to Care philosophy means ensuring that they receive improved access to intensive case management, flexible care plans in the home with CCAC services and/or access to assisted living/supportive housing, adult day programs and other community services.

Consistent eligibility criteria and admission processes to complex continuing care/rehabilitation (CCC/Rehab) and assisted living/supportive housing/adult day programs (AL/SH/ADP) have been established and implemented across the South West LHIN.

In spring 2014, the South West LHIN Board received directional recommendations for Phase II CCC/Rehab bed realignment. Implementation planning occurred in 2014-15 and continues to date with further realignment opportunities being considered. In fall 2014, the South West LHIN Board also approved changes related to the adult day program redesign. Quality improvement implementation started in 2014-15 to improve access to high quality services. Expanding services to improve access will continue in 2015/16 and 2016-17.

In addition, the Board received recommendations for the implementation of assisted living hubs enabling clients living within defined areas to receive access to scheduled and unscheduled assisted living services. Implementation planning for hubs in five communities began in fall 2014. Four of the hubs are actively supporting clients as of March 31, 2015.

Mental Health and Addiction Services

London Middlesex Crisis Centre

In 2015/16, the South West LHIN provided base investments and the Ministry of Health and Long-Term Care announced Capital funding to support the development of the London Middlesex MH&A Crisis Centre. As of January 11, 2016 the Crisis Centre has been providing 24/7 walk in support for individuals, aged 16 and over, experiencing a mental health and/or addictions crisis that do not require hospital or emergency service interventions.

A mental health and/or addictions crisis can include: a serious, immediate mental health or addictions problem, a situational crisis, psychosis, risk of self-harm or harm to others, emotional trauma, agitation or unable to sleep as a result of severe depression or anxiety, symptoms of moderate withdrawal and needing support, or suicidal thoughts.

Located at 648 Huron St. in London, the Crisis Centre provides supportive counselling and assessment for immediate crisis issues and referrals to other services for on-going, non-crisis issues. Referrals can be made by staff to treatment and case management services, social & recreational activities, life skills development, vocational and housing supports, withdrawal assessment and Telewithdrawal Management Support. The Crisis Centre houses the Crisis Mobile Team which can respond in the community and can provide referrals to the crisis stabilization beds for individuals experiencing non-emergent crisis issues.

The Crisis Centre also provides access to 5 off-site crisis stabilization beds. When the capital funding is received and renovations are complete, the 5 crisis stabilization beds will move into the Crisis Centre and 5 additional crisis stabilization beds will open.

From January 11 (opening of the crisis centre) until March 31, 2016, the Crisis Centre has served 993 clients:

- 669 (67%) were unique clients (e.g. first visit to the Crisis Centre)
- 349 (35%) would have gone to the ED if the Crisis Centre was not there
- 64 (6%) were of Indigenous Heritage
- 19 (2%) speak French as their first language

Supportive Housing Units

Further to recommendations made in June 2015, the Ministry announced $462,000 in base funding to the LHIN to provide support services in co-ordination with new supportive

housing rent supplement units for people with serious mental health issues and/or problematic substance use who are homeless or at risk of being homeless.

These investments support implementing Phase 2 of the Mental Health & Addiction Strategy: 1,000 new supportive housing units. The following allocations were made in 2015/16 (as endorsed by the LHIN Board in June 2015):

- HopeGreyBruce ($84,000/1 Full-time equivalent – supporting 8 units)
- Canadian Mental Health Association (CMHA) Oxford ($84,000/1 Full-time equivalent – supporting 8 units)
- CMHA Huron Perth ($84,000/1 Full-time equivalent – supporting 8 units)
- CMHA Middlesex ($210,000/2.5 Full-time equivalent – supporting 19 units)

Funding for 2016/17 (recommendation of an additional $168,000 to CMHA Middlesex for 2 Full-time equivalent – supporting 17 units) is expected to be confirmed next fiscal.

Anticipated outcomes include:

- More people stably housed and supported
- Using a housing first model, will empower people with mental illness and addiction to manage in the community
- Less use of homeless related services (e.g. fewer nights in shelters or transitional housing, fewer police detentions)
- Fewer avoidable hospital admissions/readmissions
- Reduced reliance on ED (repeat visits)
- Improved heath (compliance with testing and treatment, recovery, detection of illnesses)
- Reduced chronic homelessness by providing sustainable housing options

Peer Support

Beginning in 2015/16, standardized peer support models are being developed at the LHIN and sub-LHIN levels based on promising practices. LHIN-wide standards for education and training for peer supporters will be established, and work will begin to strengthen the PEERS Network (Peers Envisioning and Empowering Recovery across the South West – formally SWAN). Planning and engagement will also occur concurrently at the sub-LHIN level and integration opportunities (e.g. service, back office, governance) will be explored.

Work has begun to understand the gaps and identify opportunities to further integrate Peer Support into the mental health and addictions system in sub-regions using a phased approach:

- Phase 1 (February 2016-June 2017) London-Middlesex: ongoing meetings with Peer Support agencies and their board members (Can-Voice, Connect MH) with community mental health organizations including Canadian Mental Health Association Middlesex, Addiction Services Thames Valley, London Health Science Centre and St. Joseph's Health Care, London will begin early February.
- Phase 2 (June 2016-June 2017) will target the Elgin and Oxford areas
- Phase 3 (September 2016-June 2017) will target the Huron Perth and Grey Bruce areas.
- Work during each phase will consist of:
    - Confirming current state
    - Identifying best practice model for implementation
    - Identifying integration opportunities in sub-LHIN areas
    - Decision-making
    - Implementation

Grey Bruce mental health and addictions partners

A series of meetings were held with the four LHIN-funded mental health and addictions service providers in Grey Bruce to explore opportunities for closer alignment and collaboration among all organizations to better care for the people they serve. An external facilitator was retained to support several meetings and develop a report outlining recommendations for next steps.
A final report has been received and partners will be working towards the recommendations in early 2016/17.

Grey Bruce IDEAS project: Transitions of care for mental health and addictions patients

"Optimizing the Transitions of Care for Mental Health and Addictions patients from Hospital

to Community in Grey Bruce" was an Improving & Driving Excellence Across Sectors (IDEAS) project completed in 2015/16 that aimed to reduce 30-day readmissions for mental health and addictions patients at Grey Bruce Health Services (GBHS).

The project team presented their results on March 31, 2016 in Toronto. Some of the outcomes and learnings include:

- Standardized processes for discharge and warm-hand-offs have improved relationships and collaboration between hospital and community partners leading to better patient outcomes.
- Early identification of mental health and addictions patients requiring outpatient services upon discharge.
- It is important to understand and address the patient situational context to enhance clinical assessment and care planning.
- System gap identified in community services for mild to moderate people with mental illness who need psycho-social supports (greater prevention focus needed).
- Reasons why patients came back after 30 days is multifactorial (not one reason).
- Quality Improvement is important to Leadership and staff need dedicated time to work on quality improvement initiatives.

Next Steps:

- Streamline discharge checklist and embed into daily huddles and implement on mental health and addictions inpatient unit.
- Collaborative supports of mental health and addictions clients/patients in our community. Continue to work together as a system to support the mental health and addictions patient.
- Partnerships to ensure spread and sustainability and continued collaboration between hospital and community.
- Addictions and Mental Health Network – embed partnership and collaboration standing agenda item.
- Physician engagement needs to be improved.

Final poster presentation of project results at IDEAS in Toronto on October 19, 2016.

Behavioural Supports Ontario project: Framework for allocation of resources

The purpose of BSO is to improve the lives of older adults with responsive behaviours (including: wandering; apathy; agitation; and/or aggression) due to dementia, mental health and addiction issues, and other neurological disorders living in long-term care homes or in community settings, and their caregivers through the design and implementation of a cross-sectoral system of targeted supports and services.

The South West LHIN currently allocates more than $6 million in annualized funding to the South West LHIN-wide Behavioural Supports Ontario (BSO) system of care. The funds support nearly 80 FTEs in Schedule 1 hospitals related to the geriatric mental health outreach teams, BSO skilled nurses and PSWs in LTC Homes, social work supports through Alzheimer Societies, and Adult Day Programs offering overnight respite.

Due, in part, to the success of the system of care created, the demand for BSO services has grown dramatically, leaving many services at capacity. Organizations involved in delivering BSO services have identified a range of resource issues such as challenges meeting inflationary increases that result in a reduction of resources to cover human resource (HR) costs, and challenges meeting demand with current level of resources or type of resources originally funded. Other organizations have challenges recruiting and retaining these specialized resources resulting in inconsistent responses to demand when human resource vacancies exist. This is resulting in increased wait times for their services.

Given the strong demand for additional BSO system of care resources, the LHIN was interested in developing a structured approach to inform the allocation of future investments; one that helps the South West LHIN prioritize the greatest needs of the population as well as understand the potential impacts of funding additional resources in one area of the system of care over another.

In 2015/16, HealthStats Inc. was procured to complete a current state examination of seniors mental health and addiction services

with a focus on resources that support older adults living with responsive behaviours, and perform predictive modeling and analytics to assist the LHIN with prioritizing future investments to result in optimizing health outcomes, experience of care and value for money for this growing population.

Behavioural Support Units

In the Fall of 2014, the South West LHIN Board approved $1.8 M to provide enhanced resources to be able to create additional Long-Term Care (LTC) home specialized units for people with responsive behaviours. Following this approval, an extensive stakeholder consultation was implemented that resulted in a BSU Guidance Document. The units will be part of a coordinated continuum of care that leverages the strengths of specialist teams such as Geriatric Psychiatry and Behavioural Supports Ontario (BSO) mobile teams, and builds upon the knowledge and resources which currently exists in LTC home settings. The Guidance Document describes the characteristics of the population to be served, the care delivery approach, admission and discharge processes, care pathways and tools, and stakeholder commitments (e.g. hospitals, CCAC, and LTC Homes). The goal of the units is to stabilize behaviours and support transition until residents return to their home, which may be in another LTC home or in the community. The approximate length of stay is estimated to be 120 days although some individuals may require more time to achieve their goals.

Leveraging the guidance document, in the spring of 2015, a BSU expression of interest survey went out to all to LTC Homes in the South West LHIN. Five LTC home organizations (six physical sites) indicated that they would be interested in having a BSU located in their LTC Home.

ALC challenges have been identified as higher in both the Grey Bruce and London Middlesex sub-LHIN regions. To assist with these ALC challenges, these are the priority areas for development of BSU(s). The long term goal is to have units in each geographic area as per benchmarks (see appendix that follows).

To assist with the development of these units, a BSU Advisory Group was formed. BSU members were identified as expert resources to oversee the interview and selection process and to inform recommendations for where BSU(s) should be developed. During February and March, 2016, the group has been meeting with interested LTC homes and as of March 9, completed the first portion of interviews/information collection from the interested homes in the London Middlesex and Grey Bruce areas.

In addition to the resources at the LTC home and the supplemental staffing, residents in the BSU will also have access to the expertise, skills and services of care partners in the community. Community partners will contribute their expertise and services to assist with the implementation of a comprehensive coordinated care plan that is intended to meet the needs of each resident and maximize their quality of life. The BSU Advisory Group will ensure that the recommended LTC home(s) for BSUs will be located in an optimal space for referrals and have the right supports within the local community to provide this service optimally.

It is anticipated that recommendations for BSUs in both the London Middlesex and Grey Bruce areas will go forward in June/July 2016, with anticipation to submit formal proposals to the MOHLTC in late Fall 2016.

Approximately 15 years ago during divestment of mental health hospital beds from Parkwood, there was ability to transfer resources to enhance community capacity. These resources were utilized to create a non-designated behavioural unit in a LTC home (initially at Versa Care Lambeth and then moved to McGarrell Place in London when home redeveloped). The enhanced resources provided for 29 long stay beds in a resident home area to support individuals with mental health challenges who no longer required tertiary mental health care.

Parallel to the work to develop new BSUs, beginning in the fall of 2015, a working group was established to create a proposal to request designation of McGarrell Place specialized unit. This proposal will include the

shift to the transitional model as described in the guidance document.

It is proposed that the 25 long-stay bed Resident Home Area (reduced from 29) be permanently designated as a transitional specialized unit for people who have responsive behaviours. Enhanced resources to support this population in the specialized unit will be provided by the South West LHIN from the $1.8M noted above. It is anticipated that the proposal for the McGarrell place BSU will go forward to the Ministry in May/June 2016.

Crisis intervention standardization
Two key recommendations have come out of the refreshed Community Capacity Report (2014) with the aim of initiating the "benchmarking" mental health and addictions. These recommendations include that:

1. The South West LHIN review the capacity, function and utilization of all community-based crisis response services to determine if further standardization is required (in terms of staffing, hours of service, service delivery model and outcomes).
2. Services and the system would benefit from an overall review of capacity, function and further standardization before any additional service investments are made (e.g. crisis services, mental health counselling, residential addiction services). This recommendation could involve a review of funding levels, performance targets, service delivery models and outcomes.

Based on these recommendations, the South West LHIN has begun to conduct an analysis with the Crisis Intervention - Mental Health Functional Centre (FC). The objectives of the analysis include the establishment of equitable access to mental health and addictions crisis services across the South West LHIN based on:

- Standardized service delivery criteria/description,
- Consistent application of service expectations,
- Targets (e.g. staff/client ratios),
- Outcomes; and,
- LHIN funding/functional centre.

Community-based mental health and addictions services will be optimally standardized to:

- Reduce variation in service delivery models,
- Improve efficiency and capacity,
- Improve patient outcomes, including patient experience and effectiveness; and,
- Improve equitable access across South West LHIN geography.

There was agreement at the Addictions and Mental Health Coalition meeting that forming a working group would be the appropriate way to continue this work, with a co-chair model and possibly a facilitator from outside the South West LHIN. Leveraging the information collected, a crisis benchmarking workgroup will be formed and hold regular meetings to work through the following questions:

- What is the standard basket of crisis services/service model to be offered?
- What are the outcomes we will track / what are the targets?
- How do we ensure equitable access, consistency and quality of crisis services across the LHIN?

Representatives from all organizations providing crisis services have formed a working group and have begun meeting. The working group will continue to meet on a regular basis over the next year to move this work forward.

Coordinated access
Building on recommendations from the Community Capacity Report, mental health and addictions providers in the South area of the LHIN have been working collaboratively on aspects of coordinated access such as a shared calendar to coordinate timely access for clients, a coordinated screening and intake process, coordinated waitlist relief strategies, use of evidence based screening tools and development of a single access phone number available in both official languages. As these discussions have evolved, there has been a close look at existing and potential services to enable one-number access.

Currently there are multiple phone lines available in each county which creates challenges for people trying to access services. Some of the challenges that multiple, disconnected phone lines and services create for users include:

- Mobile crisis teams may be on a call and not be available and people have to call back, or some crisis calls may go to an answering machine (Elgin and Oxford). Neither option is appropriate for an individual in crisis.
- People have to call and book an appointment with the appropriate service following a crisis intervention (leaves follow-up to client) during regular business hours.
- People that require services from multiple providers have to call each provider to book their appointments.
- Calendar appointment access for LHIN funded mental health and addictions providers has been implemented in some, but not all areas of the South and is not yet consistently utilized.
- The evidence based screening tool that all providers are/will be utilizing (the GAIN Short Screener) is not available in a web-based format which would enable screening and sharing of the information with a referral.
- Bilingual services are not provided.

After significant consultation with community mental health and addictions service providers, consensus has been achieved to create a new coordinated access model, including one-number for the South. The new model will be a great improvement as it will provide more timely access for mental health and addictions clients who need support.

The new one-number model will include:

- General mental health and addictions information
  - Information and referral services
- Request for access to treatment
  - Direct calendar access to LHIN-funded providers in the South
  - GAIN Short Screener in web-based format for screening and sharing of the screening information with referral
- Crisis support
  - Warm transfer protocols between provider and the participating crisis services (medium risk referral to ED/Crisis Centre or warm transfer to mobile crisis as appropriate and imminent or high risk to 911). A warm transfer will ensure that callers remain on the phone with someone at all time and avoid the person having to tell their full story multiple times (e.g. if the person that has responded to the call needs to connect the caller to the crisis team, they will automatically transfer the call to the crisis team rather than the person having to call another number or wait to be called back. Alternately, the call operator can put the person on hold, provide a description of the callers needs to the crisis team and then connect the person in so they do not have to tell their story again).
  - Suicide risk assessment/violence risk assessment
- Supportive listening/brief intervention and support through volunteers
- Bilingual services as well as access to Language Line Services, 24/7/365 offering translation to over 170 languages
- Possible growth of the model to other counties and/or LHINs

It is anticipated that the new, one-number model will be implemented in early 2016/17, with full implementation by end of the fiscal year.

Mental health and addiction Capacity Planning and Mental Health Bed Registry

The Mental Health and Addiction Capacity Planning Committee has been created to develop a mental health and addictions Capacity Plan for Schedule 1 and Tertiary Mental Health Hospitals within the South West LHIN.

Over the past year, the mental health and addictions system has experienced a steady increase in patient visits to emergency departments requiring hospital admission. A high acuity of mental health patients has

created an increased demand for access to acute secure psychiatric beds and at times patients may wait for days for an inpatient bed. This has created increased wait times, increased lengths of stay for psychiatric patients, and increased Alternate Level of Care days for older adults with responsive behaviours and the difficult to serve population.

Given current system pressures, short, medium and long term solutions must be developed to address the patient access and flow challenges. One very important tool that will be used by the Committee is the Provincial Inpatient mental health and addictions Bed Registry for Ontario hospitals which was launched in December 2015. The Bed Registry Project is comprised of two mental health and addictions Resource Boards (one for Adult and one for Child and Adolescent) and a provincial mental health and addictions Addiction Dashboard, all housed within CritiCall Ontario's existing Provincial Hospital Resource System. They provide province-wide up-to-date information about the number of available inpatient beds in Ontario hospitals, and mental health and addictions inpatient bed capacity information which is based on the number of individuals waiting for inpatient beds. The bed registry will be updated 2 times per day, 7 days per week. This will allow real time data on bed availability as well as the number of patients waiting for a bed in the emergency department at each of the Schedule 1 sites.

In 2016/17, the mental health and addictions Capacity Committee will conduct a current state review of Schedule 1 Hospital Mental Health inpatient services offered across the South West LHIN and will make recommendations to improve the timely, efficient and equitable access to inpatient beds. Opportunities will be identified to optimize and align existing resources to improve patient care.

eHealth

In 2015/16 the South West LHIN continued to advance several key technology projects. While respecting the capacity and resources available, important steps were taken towards achieving excellence in health care by harnessing the power of information.

The 14 LHINs have developed a cluster-based delivery model provincially for the implementation of eHealth initiatives. There are three clusters which work together to coordinate and strategize eHealth opportunities:

- Cluster #1: South West Ontario (SWO)
- Cluster #2: Greater Toronto Area (GTA)
- Cluster #3: North East Ontario (NEO)

The SWO cluster includes the Erie St. Clair, South West, Waterloo Wellington and Hamilton Niagara Haldimand Brandt LHINs. LHINs use the cluster model to provide project leadership and oversight to ensure successful implementation and adoption of projects. The creation of the three provincial clusters (SWO, GTA, NEO) provides a mechanism to coordinate, plan, implement and maintain eHealth enabling solutions in a streamlined fashion across the province.

The role of the clusters is to:

- Support local eHealth as well as cluster or provincial (e.g. eHealth Ontario, OntarioMD, Ministry of Health) projects
- Facilitate delivery of local, cluster or provincial projects
- Represent initiatives within an individual LHIN and across a series of LHINs
- Support development and alignment provincially, locally and between clusters

The South West LHIN and stakeholders, identified several eHealth initiatives or areas of focus that have the most direct impact in helping us meet our organizational priorities and are listed below:

1. eConsultation

The eConsultation project allows primary care providers - primarily physicians and Nurse Practitioners - to communicate electronically with specialists to ask questions about a specific patient. This communication takes place over a secure web based platform provided by the Ontario Telemedicine Network (OTN). The benefits evaluation survey from the Phase 1 Pilot ending September 2015 indicated that up to 40% of potential referrals were avoided as a result of using eConsult. The project now in Phase 2 is available to all Primary Care Providers and Nurse Partcitioners in the South West LHIN. OntarioMD and Ontario Telemedicine Network (OTN) field teams continue to engage providers and promote adoption of this tool in the South West LHIN.

2. Health Links – Care Coordination Tool

The Care Coordination Tool (CCT) documents the Coordinated Care Plan (CCP) that results from care conferences across all providers and the extended circle of support involved in managing the care of Health Link patients. The CCT serves to collaborate and share timely information between those involved in the patient's care and support. The Huron Perth Health Link successfully completed piloting the Ministry of Health's electronic version of the tool (eCCT). Evaluation is currently underway to assess eCCT and other interim electronic tools currently deployed in various health links to arrive at informed decision to rollout a single provincial solution and strategy.

3. **Regional Integration (Clinical Connect)**

Connecting South West Ontario (cSWO) is a Regional eHealth Program funded by eHealth Ontario. The program involves health service providers in the four Local Health Integration Networks of Erie St. Clair, South West, Waterloo Wellington and Hamilton Niagara Haldimand Brant.

cSWO's goal is to implement a regional ehealth program that will make an individual's health information from across the continuum of care available in a timely and secure fashion at any point of care. This includes: an integrated Electronic Health Record (EHR) and a Regional Clinical Viewer, ClinicalConnect™. The regional ehealth program incorporates a number of related services, such as data support, adoption and change management, project management, privacy management and policy development.

The cSWO Program is implemented and delivered through a centralized program management approach, with London Health Sciences Centre as the delivery partner to eHealth Ontario with accountability for the cSWO Program management. There are delivery partners accountable for key components of the program, including: regional and provincial solutions, change management and adoption, and sponsorship and registration.

ClinicalConnect is a regional Clinical Viewer where authorized health care providers can view all of a patients' electronic health care information, regardless of where in the health care continuum it was collected, in real-time, from anywhere in southwestern Ontario.

ClinicalConnect is a secure online portal that provides authorized health care professionals with real-time access to their patients' electronic medical information (electronic health records) from local hospitals and Community Care Access Centres. As well, information from provincial data repositories is available, including Ontario laboratories information system (OLIS) and Southwestern Ontario Diagnostic Imaging Network Provincial Data Repositories (SWODIN).
Care providers within a patient's circle of care can readily and securely access information about their patients, including reviewing their medications and test results. This provides a complete view of the patient's clinical journey through the health system.

ClinicalConnect has been deployed to more than 15,000 health professionals in the South West LHIN as of March 31, 2016.

4. Hospital Report Systems

Hospital Report Manager (HRM) is a provincial application that enables primary care providers and specialists using OntarioMD certified Electronic Medical Record (EMR) systems anywhere in Ontario to receive patient reports electronically from participating hospitals or Independent Health Facilities (IHF).

The cSWO Program and the cSWO change management and adoption delivery partners are working collaboratively with OntarioMD on the solution deployment/integration of the HRM, including active engagement with the sending facilities (hospitals) and receiving organizations (clinicians). By March 2016, 193 clinicians were using HRM. In 2016-2017 HRM will continue to be deployed systematically to primary care physicians across South West Ontario, enhancing their access to EMR download services in conjunction to the functionality offered through SPIRE.

5. Resource Matching and Referral

This initiative is a critical component in supporting a positive patient experience during transitions. Through this initiative there is a plan for provincial standardization of referral data from acute care to the four in scope pathways: Long-Term Care (LTC), Community Care Access Centre (CCAC), Complex Continuing Care (CCC) and Rehabilitation (Rehab). Progress to date on the Resource Matching and Referral (RM&R) initiative is the result of significant engagement and collaboration with health service provider stakeholders across the province.

Since the Provincial Referral Standards were finalized and approved in early 2014, individual LHINs have been tasked with implementing the Referral Standards at all remaining HSPs within their LHIN. In 2015/16, significant progress was made in our LHIN in each pathway. The Acute to LTC pathway is 100 per cent complete and are using the provincial standards. In the Complex Continuing Care and Rehab pathways 84 per cent of hospitals in the South West LHIN are now using the provincial standards. Additional progress has been made in creating electronic forms to capture and record the referral information resulting in more efficient processes for clinicians.

6. Surgical Wait List Management

A surgical waitlist management system is an electronic, web based solution that includes:

- Automated reporting to the provincial Wait Time Information System;
- Real time wait time management in surgeons' offices;
- Real time business intelligence for surgical waitlist management at all levels of the organization;
- Improved performance management and accountability;
- eScheduling from the physician office; and
- Paperless eBookings.

In 2015/16, the St. Thomas Elgin General Hospital lead the first implementation and successful procurement of an electronic system. Early evaluation has shown improvements in wait times (wait 2), OR utilization, same day cancellation rates, and reduced staff time on clerical, booking and data entry. Additional hospitals are targeted to go live in 2016-17.

7. Telehomecare

Telehomecare is an Ontario Telemedicine Network (OTN) project that allows remote monitoring of amenable patients with Chronic Obstructive Pulmonary Disease and Congestive Heart Failure at home. A remote monitoring nurse engages to support amenable patients for remote monitoring, coaching and self-management. The program is part of an integrated care process that involves the primary care provider and associated agencies providing care to the patient. The South West LHIN has successfully enrolled over 330 patients in 2015/16 and

continues to explore newer models of care that are sustainable and available to a greater number of eligible patients.

Health System Funding Reform

Health System Funding Reform's (HSFR) two components – the Health Based Allocation Model (HBAM) and Quality Based Procedures (QBPs) look at quality, utilization and cost across South West LHIN hospitals and the CCAC.

HBAM calculates a hospital's share of the overall available funding by comparing an expected (standardized) total cost for the hospital to the sum of the expected cost of all Ontario hospitals; a single hospital's percentage share of the total provincial expected cost then determines the share of the available funding. Hospitals in the high growth areas of the province are receiving an increasing share of the available funding as additional patient activity increases the total expected cost. The South West LHIN is growing, but not at the same pace as the Greater Toronto Area, and this results in flat or diminishing HBAM revenue for most of our hospitals.

South West LHIN hospitals have responded by controlling unit costs. For example, acute and day surgery is the largest cost component of the HBAM model. South West LHIN hospitals have managed to stay close to 2011/12 unit cost levels and three of the seven large hospitals: Stratford, Strathroy and Woodstock reduced unit costs from 2011/12 to 2014/15.

The shift of HBAM funding to high growth areas will still be a challenge for most of our hospitals in the coming years. The HSFR Local Partnership Committee comprised of the hospitals, CCAC, and the LHIN is working cooperatively to adapt to anticipated HBAM funding levels.

QBP funding is provided using a price per procedure (volume) formula. This year QBP funding will be higher than last year as $25 million was added to the LHIN-managed QBP envelope at the provincial level, which equates to an extra $1.9 million for the South West LHIN. Funded volumes for QBP procedures such as hip and knee replacements have not shifted from low growth to high growth areas, however, new growth funding has added volumes to the high growth areas surrounding Toronto.

Aligning to QBP funding requires adopting best practices as defined in the QBP clinical handbooks and controlling costs to match the QBP prices. A pan-LHIN QBP Assessment Survey was developed and implemented in 2015/16 in order to profile the current state related to QBP implementation across the province, identify potential areas where collective action could increase efficiency and improve performance, and provide an update on emerging opportunities and next steps.

Results have been shared and the focus has now shifted to include a profile on outcomes related to the COPD QBP. A key focus is to identify peer leaders based on more timely access to data and information.

The South West LHIN has been working with our HSFR Local Partnership Committee in order to expand their focus to include an oversight role related to improvement in key QBP outcomes. Additionally, in partnership with Health Quality Ontario, a Clinical Quality Table (CQT) has been established as an action-oriented, clinically-focused body, focused on regional quality challenges and initiatives, aligned to supporting the advancement of key priorities within the Integrated Health Service Plan with an initial focus on improving patient outcomes for individuals with selected chronic conditions as well as mental health and addiction related co-morbidities.

Wait Times for surgical and diagnostic imaging procedures

Surgical Waitlist Management

The South West LHIN has made an initial investment in a Surgical Waitlist Management System (Novari) that will enable the creation of a "virtual centralized" queue in order to improve access to surgery. The St. Thomas Elgin General Hospital is the first hospital in the LHIN to implement the surgical waitlist

management solution. Hospitals in other LHINs that have implemented this system have seen sustained improvement in their access to surgery over time.

The LHIN is in the process of implementing and spreading the information across the LHIN hospitals. The "central cluster" (Huron Perth Healthcare Alliance, Alexandra Marine General Hospital, Listowel Wingham Hospital Alliance) are the furthest along in the Novari implementation readiness work.

Orthopedics Committee
The South West LHIN Orthopedics Steering Committee has been identified as a vehicle to impact quality improvement and create a system of orthopedic care across the South West. Discussions are currently taking place to identify appropriate stakeholders, Terms of Reference and initial meeting dates.

Vision Care
The LHIN has provided funding through the Priorities for Investment Fund to support the following three streams of work in the current fiscal year and into 2016/17.

Focus for 2015 – 2016:

- Development of a case-based approach to clinical decision-making and coordination of care for people with complex eye problems and complex medical conditions
    - The project team has adopted a process for case conferences modelled after the process utilized by the London Regional Cancer program (LRCP).
    - There have been delays with recruiting and booking meetings with work group team members; ophthalmologists require more time to observe and debrief about the LRCP multidisciplinary case conference review process.
    - In light of the delays mentioned above a change to Complex Eye sub-project schedule requested to move March 31, 2016 project end date to May 31, 2016 (2 month extension), allowing time to engage all significant stakeholders in planning and piloting. It is expected that high stakeholder participation will result in the best project outcomes. To avoid a budget variance, we simultaneously request an early start (2 months) for the next approved Vision Care Project. These changes were supported by the South West LHIN. The close out report will now be submitted June 28, 2016.

Diagnostics Initiatives to Improve Wait Times:
The South West LHIN has invested $410,000 to improve the diagnostics wait times. In partnership with the regional and local stakeholders we are creating a new regional model called the Medical Imaging – Regional Service Model. This new model of regional and system collaboration for hospital based medical imaging services will enhance the patient experience through coordinated access and quality of service (which includes system strategies for: scheduling, patient access, utilization, appropriateness by provider type, human resources, equipment utilization, real time quality/access metrics).

The Regional Medical Imaging Committee identified three key areas of focus to improve imaging services within the region:

Standardization of Quality – Leveraging the opportunity to standardize protocols, LHIN wide peer review practices and established quality metrics for imaging services.

Appropriateness – Using improved access to prior exams, a common and improved ordering/referral/scheduling system that supports appropriateness/urgency, online education at the point of ordering, and information filtering for radiologist prioritization, looking at all modalities.

Access – A waitlist management strategy includes supporting the designation of what services are available at what sites based on sub-specialty skills, equipment features and appropriate equipment utilization, and mechanisms to real-time direct demand to where capacity exists to improve the LHIN wide wait list across all modalities.

Diabetes Program Update
In 2015/16 coordination and integration of care has been enhanced for people in the

South West LHIN living with and managing diabetes. Provincially, five working groups are now established comprised of health system partners in government, acute care, and in community services. Most notably, headway was made in consolidating data collection and reporting throughout the LHINs to ensure the data better reflects the diversity of patient needs amongst various population sand geographies. This data will directly contribute to the development of system-level indicators for diabetes work.

Additionally, much work in the South West LHIN has occurred to establish coordinated access for diabetes education. The Diabetes Coordinated Access project aim is to work with the diabetes education programs to develop standard work around intake, referral and placement of patients. This work is currently being piloted with several Health Service providers in the London area. We will continue to focus on spreading these standards across the geography in the upcoming year.

The Diabetes Foot Care project is an integrated, interdisciplinary team delivery model that leverages existing services and organizations to address diabetes foot care in the London area using risk-based stratification. The project ended this fiscal year with several recommendations put forward to ensure this work is continued and momentum is maintained. The project will be scoped within the larger Diabetes Coordinated Access project to ensure linkages between intake and referral processes, and formal testing of the harmonized risk stratification model.

SOUTH WEST LHIN MLAA INDICATORS
2015/16 ANNUAL REPORT DATA

No.	Indicator	Provincial target	Provincial			LHIN		
			2014/15 Fiscal Year Result	Most Recent Quarter	2015/16 Result (year-to-date)	2014/15 Fiscal Year Result	Most Recent Quarter	2015/16 Result (year-to-date)
1. Performance Indicators								
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	85.39%	86.55%	85.28%	90.87%	87.41%	89.14%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	93.71%	93.21%	93.66%	92.59%	92.70%	93.15%
3	90th Percentile Wait Time for CCAC In-Home Services - Application from Community Setting to first CCAC Service (excluding case management)*	21 days	29.00	29.00	30.00	21.00	21.00	20.00
4	90th percentile emergency department (ED) length of stay for complex patients	8 hours	10.13	10.48	9.97	8.37	8.00	7.73
5	90th percentile emergency department (ED) length of stay for minor/uncomplicated patients	4 hours	4.03	4.28	4.07	3.62	3.78	3.62
6	Percent of priority 2, 3 and 4 cases completed within access target for MRI scans	90.00%	41.75%	40.37%	38.41%	34.41%	37.74%	33.92%
7	Percent of priority 2, 3 and 4 cases completed within access target for CT scans	90.00%	77.77%	74.08%	74.60%	76.82%	83.69%	78.43%
8	Percent of priority 2, 3 and 4 cases completed within access target for hip replacement	90.00%	81.51%	79.63%	79.97%	76.53%	67.57%	68.39%
9	Percent of priority 2, 3 and 4 cases completed within access target for knee replacement	90.00%	79.76%	78.18%	79.14%	76.83%	69.80%	68.86%
10	Percentage of Alternate Level of Care (ALC) Days*	9.46%	14.35%	14.15%	14.16%	8.39%	9.48%	8.77%
11	ALC rate	12.70%	13.70%	14.12%	13.98%	9.65%	11.86%	11.05%
12	Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions*	16.30%	19.62%	20.33%	20.28%	17.64%	17.99%	18.01%
13	Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions*	22.40%	31.34%	33.39%	33.42%	21.08%	23.71%	23.23%
14	Readmission within 30 days for selected HIG conditions**	15.50%	16.60%	16.62%	16.51%	17.34%	16.05%	16.68%
2. Monitoring Indicators								
15	Percent of priority 2, 3 and 4 cases completed within access target for cancer surgery	90.00%	87.02%	86.56%	88.03%	81.49%	80.88%	84.29%
16	Percent of priority 2, 3 and 4 cases completed within access target for cardiac by-pass surgery	90.00%	96.01%	94.00%	95.00%	98.92%	100.00%	98.00%
17	Percent of priority 2, 3 and 4 cases completed within access target for cataract surgery	90.00%	91.93%	87.37%	88.09%	88.52%	92.32%	91.27%
18 (a)	CCAC wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	14.00	15.00	14.00	8.00	8.00	8.00
18 (b)	CCAC wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	8.00	7.00	8.00	4.00	6.00	5.00
19	Rate of emergency visits for conditions best managed elsewhere per 1,000 population*	NA	19.56	4.58	12.86	46.03	10.65	29.65
20	Hospitalization rate for ambulatory care sensitive conditions per 100,000 population*	NA	320.78	80.87	235.64	389.32	100.35	285.49
21	Percentage of acute care patients who had a follow-up with a physician within 7 days of discharge**	NA	46.09%	45.55%	46.58%	40.80%	41.27%	42.29%

*FY 2015/16 is based on the available data from the fiscal year (Q1-Q3, 2015/16)
**FY 2015/16 is based on the available data from the fiscal year (Q1-Q2, 2015/16)

The MLAA outlines obligations and responsibilities of both the South West LHIN and the Ministry of Health and Long-Term Care (MOHLTC) and specifies indicators targeted for improvement. The 2015-2018 MLAA reflects alignment with the new government priorities and initiatives including the Patients First Action Plan for Health Care, and transformation activities including: Health System Funding Reform (HSFR), Health Links, Home and Community Care, Comprehensive Mental Health and Addictions Strategy, and Palliative Care. Effective 2015/16, the Ministry shifted to using a single target for each indicator for all LHINs versus LHIN-specific targets. LHINs must report on and demonstrate progress towards achieving the provincial targets for *performance* indicators and report on and monitor the results of the *monitoring* indicators.

The above table reports on the performance of the South West LHIN on key MLAA measures.

Performance Indicators:

Considering both the most recent quarter of data and the annual performance result, the South West LHIN has either met the provincial target or made progress against the 2014/15 result of the following MLAA performance indicators:

- 90th Percentile Wait Time for CCAC In-Home Services: Application from Community Setting to first CCAC Service (excluding case management).
    - Despite a slight dip in the most recent quarter for percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services, a small improvement in the annual result is observed over 2014/15.
- 90th percentile emergency department (ED) length of stay for complex patients.
- 90th percentile emergency department (ED) length of stay for minor/uncomplicated patients
- Percent of priority 2, 3 and 4 cases completed within access target for CT scans
- ALC rate.
    - Despite a slight increase in the most recent quarter for percentage of Alternate Level of Care (ALC) days above target, the South West LHIN's annual results (8.77%) remain below the provincial target of 9.46% and well below the provincial result of 14.16%.
- Readmission within 30 days for selected HIG conditions.

LHIN/provider actions and initiatives that contributed to the improved outcomes include:

- Focus performance monitoring discussions with CCAC to include MLAA measures.
- ED Pay-for-Results - targeted improvement and investment approach at high volume ED sites; LHSC (the highest volume ED) focused on improvement interventions, including Emergency Department system improvement, admitted system transformation, and strengthening the mental health system.
- Investments in CCAC nursing to support Home First patients; investments made to increase access to Assisted Living spaces based on demographic data and demand; Behavioural Supports Ontario provides coordination and expertise in supporting and transitioning difficult-to-serve ALC clients; and planning for additional Behavioural Support Unit (BSU) capacity.

Considering both the most recent quarter of data and the annual performance result, the South West LHIN has not achieved the provincial target for percent of priority 2, 3 and 4 cases completed within access target for MRI scans, although the most recent quarter showed a slight improvement over 2014/15. Demand for this modality is increasing; therefore, the LHIN's support of the Diagnostic Imaging Regional Approach and MRI Performance Improvement Program (PIP) Scorecard to better understand referrals, demand, complexity of cases and efficiency will be important going forward.

The LHIN has neither achieved the provincial target, nor improved, when compared to the 2014/15 for the following performance indicators:

- Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services. The South West LHIN did, however, achieve better results than the province.
- Percent of priority 2, 3 and 4 cases completed within access target for hip replacement
- Percent of priority 2, 3 and 4 cases completed within access target for knee replacement

- Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions
- Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions

Some of the challenges that may have contributed to these outcomes include:

- Though 2015/16 hip and knee QBP volumes were similar to 2014/15 levels, some South West LHIN hospitals completed funded volumes by the end of Q3, negatively impacting wait times.
- Observed increases in co-occurring mental health and/or substance abuse conditions in patients who frequently visit the ED.

Actions the LHIN has undertaken or plans to undertake to improve performance include:

- Surgical Wait List Management System planning and implementation; individual follow-up meetings with all providers regarding volume and access challenges.
- Enhanced community capacity for Transitional Case Management and Crisis Services including five stabilization beds and 24/7 walk-in access to the Crisis Centre opened to provide short-term support for individuals with a mental health and/or addictions crisis in London; community mental health partners are collaborating to develop a Coordinated Access model of care to improve accessibility and are working to identify potential service gaps and improvement opportunities for patients who frequently visit the ED.

Monitoring Indicators:

Considering both the most recent quarter of data and the annual performance result, the South West LHIN continues to surpass the target for percent of priority 2, 3 and 4 cases completed within access target for cardiac by-pass surgery and has met the provincial target and demonstrated improvements over 2014/15 for percent of priority 2, 3 and 4 cases completed within access target for cataract surgery. Though there are no provincial targets, the South West LHIN demonstrated better results than the province for CCAC wait times from application to eligibility determination for long-term care home placements: from community setting and CCAC wait times from application to eligibility determination for long-term care home placements: from acute-care setting.

Despite a decline in performance for the most recent quarter, the annual result for percent of priority 2, 3 and 4 cases completed within access target for cancer surgery has improved over 2014/15, but comes up short of meeting the provincial target. A number of hospitals missed the target of 90%. Follow-up through the Regional Cancer Program and through the Service Accountability Agreement (SAA) quarterly performance review will initiate a series of progressive performance management steps that typically include: explanations of variance, improvement plans, enhanced reporting requirements, or performance meetings.

Though there are no provincial targets, the annual province rates of emergency visits for conditions best managed elsewhere (per 1,000 population), hospitalizations for ambulatory care sensitive conditions (per 100,000 population), and percentage of acute care patients who had a follow-up with a physician within 7 days of discharge are all better than the South West LHIN. These measures inherently require cross-sector collaboration to improve and are therefore not corrected easily. Spreading best hospital discharge practices including improving communication between primary health care providers and hospitals and supporting and facilitating the development of Health Links represent actions the LHIN has undertaken to improve performance. Further, as we transition into the next 3-year IHSP with a greater emphasis on collaboration, integration and shared accountability, health service providers across all sectors will be stretched to contribute to improvements in these system measures.

Operational Performance

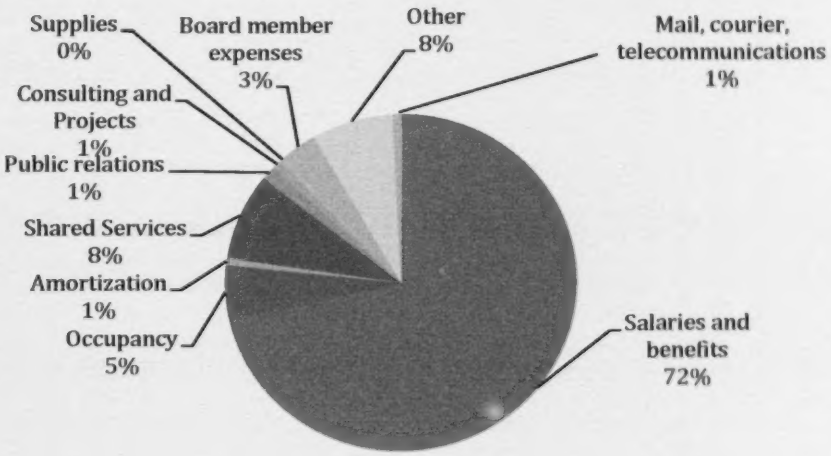
In 2015/16, the South West LHIN operating budget was made up of two components:

- $5.0 million for operations
- $2.1 million for special projects

Operations

The South West LHIN ended the year with an operating surplus of $228. Surpluses are returned to Ministry of Health and Long-Term Care (MOHLTC). The chart below shows the 10 major categories of expenditures for the South West LHIN. Our largest expenditure was salaries and benefits with 35 full-time employees (FTEs) which included two contract staff. The LHIN also had one seconded position.

Operational Expenditures 2015/16



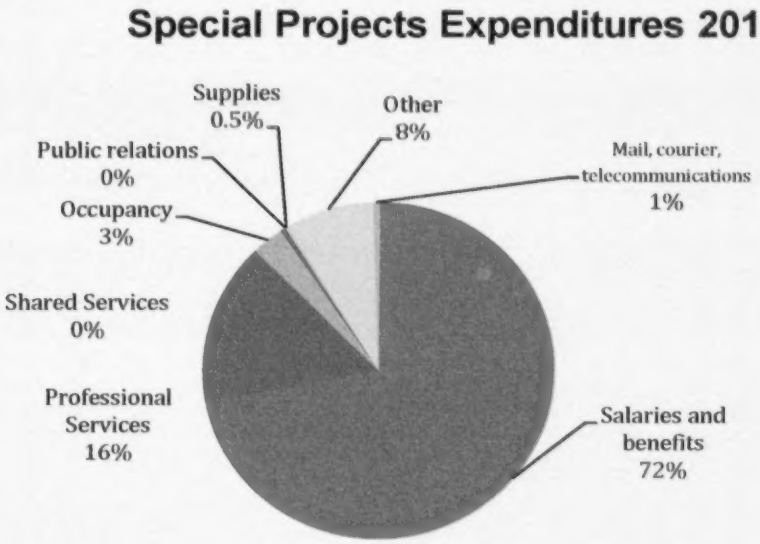
Salaries and benefits	**$3,609,224**
Occupancy	**$265,928**
Amortization	**$32,826**
Shared services	**$371,522**
LHIN Collaborative	**$46,857**
Public relations	**$68,182**
Consulting and Project expenses	**$44,766**
Supplies	**$20,987**
Board chair per diem	**$46,536**
Board member per diem	**$74,271**
Board member expenses	**$47,062**
Mail, courier and telecommunications	**$43,255**
Other	**$379,207**
	$5,050,623

Special Projects

The South West LHIN ended the year with surpluses of $5,258 relating to the funding for other special projects. Surpluses are returned to Ministry of Health and Long-Term Care. The chart below shows the 8 major categories of expenditures for the projects. Again, the largest expenditure was salaries and benefits with 14 full-time employees (FTEs) which included two contract staff.

The base and one-time funding received and expenditures by the South West LHIN to undertake planning and development for special projects during the 2015/16 fiscal year were:

Salaries and benefits	**$1,540,912**
Professional services	**$332,541**
Shared services	**$10,142**
Occupancy	**$63,433**
Public relations and community engagement	-
Supplies	**$3,846**
Mail, courier and telecommunications	**$13,032**
Other	**$175,359**
	$2,139,265



Enabling Technology Integration (ETI PMO)

Effective January 31, 2014, the LHIN entered into an agreement with three LHINs, Erie St. Clair, Hamilton Niagara Haldimand Brant and Waterloo Wellington (the "cluster"), in order to enable the effective and efficient delivery of e-health programs and initiatives within the geographic area of the cluster. The total cluster funding received for the year ended March 31, 2016 was $2,040,000. Funding of $1,530,000 was allocated to other LHINs within the cluster who incurred eligible expenses of $1,530,000. The South West LHIN had expenses of $509,487 relating to ETI PMO funding.

Financial statements of

South West Local Health Integration Network

March 31, 2016

South West Local Health Integration Network

March 31, 2016

Table of contents

Independent Auditor's Report 1-2

Statement of financial position 3

Statement of operations 4

Statement of change in net debt 5

Statement of cash flows 6

Notes to the financial statements 7-14

Deloitte.

Deloitte LLP
5140 Yonge Street
Suite 1700
Toronto ON M2N 6L7
Canada

Tel: 416-601-6150
Fax: 416-601-6151
www.deloitte.ca

Independent Auditor's Report

To the Members of the Board of Directors of the
South West Local Health Integration Network

We have audited the accompanying financial statements of South West Local Health Integration Network, which comprise the statement of financial position as at March 31, 2016, and the statements of operations, change in net debt and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian public sector accounting standards, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained in our audit is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of South West Local Health Integration network as at March 31, 2016 and the results of its operations, changes in its net debt, and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Deloitte LLP

Chartered Professional Accountants
Licensed Public Accountants
May 17, 2016

South West Local Health Integration Network

Statement of financial position
as at March 31, 2016

	2016	2015
	$	$
Financial assets		
Cash	435,353	412,804
Due from Ministry of Health and Long-Term Care ("MOHLTC") Health Service Provider ("HSP") transfer payments (Note 9)	13,455,322	13,800,587
Harmonized sales tax receivable	36,227	81,988
Due from Waterloo Wellington LHIN (Note 3c)	-	55,905
	13,926,902	14,351,284
Liabilities		
Accounts payable and accrued liabilities	424,798	453,340
Due to Health Service Providers ("HSPs") (Note 9)	13,455,322	13,800,587
Due to MOHLTC (Note 3b)	61,122	55,636
Due to the LHIN Shared Services Office (Note 4)	8,708	58,879
Deferred capital contributions (Note 5)	43,594	68,725
	13,993,544	14,437,167
Net debt	(66,642)	(85,883)
Commitments (Note 6)		
Non-financial assets		
Prepaid expenses	23,048	17,158
Tangible capital assets (Note 7)	43,594	68,725
	66,642	85,883
Accumulated surplus	-	-

Approved by the Board

Director

Director

The accompanying notes to the financial statements are an integral part of these financial statements.

South West Local Health Integration Network

Statement of operations
year ended March 31, 2016

	Budget (Note 8)	2016 Actual	2015 Actual
	$	$	$
Revenue			
MOHLTC funding			
HSP transfer payments (Note 9)	2,239,055,748	2,258,840,834	2,250,035,712
Operations of LHIN	4,895,719	5,018,025	4,875,026
Project Initiatives			
Aboriginal Planning	35,000	35,000	35,000
French Language Services	106,000	106,000	104,595
Critical Care	75,000	75,000	75,000
Emergency Department ("ED") Lead	75,000	75,000	75,000
Emergency Room/Alternative Level of Care ("ER/ALC") Performance Lead	100,000	100,000	98,576
Primary Care Lead	75,000	75,000	75,000
Enabling Technologies ETI PMO	2,040,000	2,040,000	2,007,086
Diabetes Regional Coordinating Centre	1,192,370	1,168,523	1,179,307
Amortization of deferred capital contributions (Note 5)	111,406	32,826	111,406
	2,247,761,243	2,267,566,208	2,258,671,708
Enabling Technologies ETI PMO allocated to other LHIN's	(1,530,000)	(1,530,000)	(1,530,000)
Funding repayable to the MOHLTC (Note 3a)	-	(5,486)	269
	2,246,231,243	2,266,030,722	2,257,141,977
Expenses			
Transfer payments to HSPs (Note 9)	2,239,055,748	2,258,840,834	2,250,035,712
General and administrative (Note 11)	5,007,125	5,050,623	4,985,134
Project Initiatives (Note 10)			
Aboriginal Planning	35,000	34,930	34,638
French Language Services	106,000	105,774	104,555
Critical Care	75,000	72,886	73,374
ED Lead	75,000	74,972	73,728
ER/ALC Performance Lead	100,000	99,746	98,372
Primary Care Lead	75,000	73,127	74,457
Enabling Technologies	510,000	509,487	485,540
Diabetes Regional Coordinating Ctr	1,192,370	1,168,343	1,176,467
	2,246,231,243	2,266,030,722	2,257,141,977
Annual surplus and accumulated surplus, end of year	-	-	-

The accompanying notes to the financial statements are an integral part of these financial statements.

South West Local Health Integration Network

Statement of change in net debt
year ended March 31, 2016

	2016 Actual	2015 Actual
	$	$
Annual surplus	-	-
Change in prepaid expenses, net	**(5,890)**	38,494
Acquisition of tangible capital assets	**(7,695)**	(39,499)
Amortization of tangible capital assets	**32,826**	111,406
Decrease in net debt	**19,241**	110,401
Net debt, beginning of year	**(85,883)**	(196,284)
Net debt, end of year	**(66,642)**	(85,883)

The accompanying notes to the financial statements are an integral part of these financial statements.

South West Local Health Integration Network

Statement of cash flows
year ended March 31, 2016

	2016	2015
	$	$
Operating transactions		
Annual surplus	-	-
Less items not affecting cash		
Amortization of capital assets	**32,826**	111,406
Amortization of deferred capital contributions (Note 5)	**(32,826)**	(111,406)
Changes in non-cash operating items		
Increase in due from MOHLTC HSP transfer payments	**345,265**	(2,262,670)
Decrease in due from LHIN Shared Services Office	-	-
(Increase) decrease in accounts receivable	**55,905**	(55,905)
(Increase) decrease in Harmonized Sales Tax receivable	**45,761**	(22,197)
Increase (decrease) in accounts payable and accrued liabilities	**(28,542)**	30,947
Increase in due to HSPs	**(345,265)**	2,262,670
(Decrease) increase in due to MOHLTC	**5,486**	(482,177)
Increase in due to LHIN Shared Services Office	**(50,171)**	55,563
Decrease (increase) in prepaid expenses	**(5,890)**	38,494
	22,549	(435,275)
Capital transaction		
Acquisition of tangible capital assets	**(7,695)**	(39,499)
Financing transaction		
Deferred capital contributions received (Note 5)	**7,695**	39,499
Net decrease in cash	**22,549**	(435,275)
Cash, beginning of year	**412,804**	848,079
Cash, end of year	**435,353**	412,804

The accompanying notes to the financial statements are an integral part of these financial statements.

1. Description of business

The South West Local Health Integration Network was incorporated by Letters Patent on July 9, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the *Local Health System Integration Act, 2006* (the "Act") as the South West Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to income taxation.

The LHIN is, and exercises its powers only as, an agent of the Crown. Limits on the LHIN's ability to undertake certain activities are set out in the Act.

The mandates of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The LHIN covers approximately 22,000 square kilometers from Tobermory in the north to Long Point in the south. The LHIN enters into service accountability agreements with service providers.

The LHIN is funded by the Province of Ontario in accordance with the Ministry-LHIN Performance Agreement ("MLPA"), which describes budget arrangements established by the MOHLTC. These financial statements reflect agreed funding arrangements approved by the MOHLTC. The LHIN cannot authorize an amount in excess of the budget allocation set by the MOHLTC.

The LHIN assumed responsibility to authorize transfer payments to HSPs, effective April 1, 2007. The transfer payment amount is based on provisions associated with the respective HSP Accountability Agreement with the LHIN. Throughout the fiscal year, the LHIN authorizes and notifies the MOHLTC of the transfer payment amount; the MOHLTC, in turn, transfers the amount directly to the HSP. The cash associated with the transfer payment does not flow through the LHIN bank account.

The LHIN statements do not include any Ministry managed programs.

The LHIN is also funded by eHealth Ontario in accordance with the eHealth Ontario - LHIN Transfer Payment Agreement ("TPA"), which describes budget arrangements established by eHealth Ontario. These financial statements reflect agreed funding arrangements approved by eHealth Ontario. The LHIN cannot authorize an amount in excess of the budget allocation set by eHealth Ontario.

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian public sector accounting standards. Significant accounting policies adopted by the LHIN are as follows:

Basis of accounting

Revenues and expenses are reported on the accrual basis of accounting. The accrual basis of accounting recognizes revenues in the fiscal year that the events giving rise to the revenues occur and they are earned and measurable; expenses are recognized in the fiscal year that the events giving rise to the expenses are incurred, resources are consumed, and they are measurable.

Through the accrual basis of accounting, expenses include non-cash items, such as the amortization of tangible capital assets.

2. Significant accounting policies (continued)

Government transfer payments

Government transfer payments from the MOHLTC are recognized in the financial statements in the year in which the payment is authorized and the events giving rise to the transfer occur, performance criteria are met, and reasonable estimates of the amount can be made.

Certain amounts, including transfer payments from the MOHLTC, are received pursuant to legislation, regulation or agreement and may only be used in the conduct of certain programs or in the completion of specific work. Funding is only recognized as revenue in the fiscal year the related expenses are incurred or services performed. Unspent amounts are recorded as payable to the MOHLTC at period end. In addition, certain amounts received are used to pay expenses for which the related services have yet to be performed.

Deferred capital contributions

Any amounts received that are used to fund expenses that are recorded as tangible capital assets, are recorded as deferred capital revenue and are recognized as revenue over the useful life of the asset reflective of the provision of its services. The amount recorded under "revenue" in the statement of operations, is in accordance with the amortization policy applied to the related tangible capital asset recorded.

Tangible capital assets

Tangible capital assets are recorded at historic cost. Historic cost includes the costs directly related to the acquisition, design, construction, development, improvement or betterment of tangible capital assets. The cost of tangible capital assets contributed is recorded at the estimated fair value on date of contribution. Fair value of contributed tangible capital assets is estimated using the cost of asset or, where more appropriate, market or appraisal values. Where an estimate of fair value cannot be made, the tangible capital asset would be recognized at nominal value.

Maintenance and repair costs are recognized as an expense when incurred. Betterments or improvements that significantly increase or prolong the service life or capacity of a tangible capital asset are capitalized. Computer software is recognized as an expense when incurred.

Tangible capital assets are stated at cost less accumulated amortization. Tangible capital assets are amortized over their estimated useful lives as follows:

Computer equipment	3 years straight-line method
Leasehold improvements	Life of lease straight-line method
Office equipment, furniture and fixtures	5 years straight-line method
Web development	3 years straight-line method

For assets acquired or brought into use, during the year, amortization is provided for a full year.

Segment disclosures

A segment is defined as a distinguishable activity or group of activities for which it is appropriate to separately report financial information. Management has determined that existing disclosures in the statement of operations and within the related notes for both the prior and current year sufficiently discloses information of all appropriate segments and, therefore, no additional disclosure is required.

Use of estimates

The preparation of financial statements in conformity with Canadian public sector accounting standards requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Significant items subject to such estimate and assumptions include valuation of accrued liabilities and useful lives of the tangible capital assets. Actual results could differ from those estimates.

3. Funding repayable to the MOHLTC

In accordance with the MLPA, the LHIN is required to be in a balanced position at year end. Thus, any funding received in excess of expenses incurred, is required to be returned to the MOHLTC.

In accordance with the TPA, the LHIN is required to be in a balanced position at year end. Thus, any funding received in excess of expenses incurred, is required to be returned to eHealth Ontario.

a) The amount repayable to the MOHLTC related to current year activities is made up of the following components:

	Funding	Eligible expenses	2016 Funding excess	2015 Funding excess
	$	$	$	$
Transfer payments to HSPs	2,258,840,834	2,258,840,834		-
LHIN operations	5,018,025	5,017,797	228	1,298
Aboriginal Planning	35,000	34,930	70	362
French Language Services	106,000	105,774	226	40
Enabling Technologies	2,040,000	2,039,487	513	47,451
Critical Care Lead	75,000	72,886	2,114	1,626
ED Lead	75,000	74,972	28	1,272
Primary Care Lead	75,000	73,127	1,873	543
ER/ALC Lead	100,000	99,746	254	204
Diabetes Regional Coor. Centres	1,168,523	1,168,343	180	2,840
	2,267,533,382	2,267,527,896	5,486	55,636

b) The amount due to the MOHLTC at March 31 is made up as follows:

	2016	2015
	$	$
Due to MOHLTC, beginning of year	55,636	537,813
Funding repaid to MOHLTC	-	(537,813)
Funding repayable to the MOHLTC related to current year activities (Note 3a)	4,973	8,185
Funding repayable to the MOHLTC related to current year ETI PMO Cluster activities	513	47,451
Due from MOHLTC, end of year	61,122	55,636

c) Enabling Technologies for Integration (ETI PMO)

Effective January 31, 2014, the LHIN entered into an agreement with Erie St. Clair, Hamilton Niagara Haldimand Brant and Waterloo Wellington (the "Cluster") in order to enable the effective and efficient delivery of e-health programs and initiatives within the geographic area of the Cluster. Under the agreement, decisions related to the financial and operating activities of the Enabling Technologies for Integration Project Management Office are shared. No LHIN is in a position to exercise unilateral control.

The South West LHIN is designated the Lead LHIN with this agreement and as such holds the accountability over the distribution of the funds and manages the shared Project Management Office. In the event that the Cluster experiences a surplus the Lead LHIN is responsible for returning those funds to the MOHLTC. The total Cluster funding received for the year ended March 31, 2016 was $2,040,000 (2015 - $2,040,000).

3. Funding repayable to the MOHLTC and eHealth Ontario (continued)

Funding of $1,530,000 (2015 - $1,530,000) was allocated to other LHIN's within the cluster who incurred eligible expenses of $-1,530,000 (2015 - $1,474,095). The LHIN has setup a payable to the MOHLTC for $513.

The following provides condensed financial information for the ETI PMO funding and expenses for the cluster:

	Funding allocated	Eligible expenses	2016 Excess funding	2015 Excess funding
	$	$	$	$
Erie St. Clair LHIN	510,000	510,000	-	-
Hamilton Niagara Haldimand Brant LHIN	510,000	510,000	-	-
Waterloo Wellington LHIN	510,000	510,000	-	55,905
South West LHIN	510,000	509,487	513	(8,454)
	2,040,000	2,039,487	513	47,451

4. Related party transactions

The LHIN Shared Services Office (the "LSSO") is a division of the Toronto Central LHIN and is subject to the same policies, guidelines and directives as the Toronto Central LHIN. The LSSO, on behalf of the LHINs is responsible for providing services to all LHINs. The full costs of providing these services are billed to all the LHINs. Any portion of the LSSO operating costs overpaid (or not paid) by the LHIN at the year-end are recorded as a receivable (payable) from (to) the LSSO. This is all done pursuant to the shared service agreement the LSSO has with all the LHINs.

The LHIN Collaborative (the "LHINC") was formed in fiscal 2010 to strengthen relationships between and among health service providers, associations and the LHINs, and to support system alignment. The purpose of LHINC is to support the LHINs in fostering engagement of the health service provider community in support of collaborative and successful integration of the health care system; their role as system manager; where appropriate, the consistent implementation of provincial strategy and initiatives; and the identification and dissemination of best practices. LHINC is a LHIN-led organization and accountable to the LHINs. LHINC is funded by the LHINs with support from the MOHLTC.

5. Deferred capital contributions

	2016	2015
	$	$
Balance, beginning of year	68,725	140,632
Capital contributions received during the year (Note 8)	7,695	39,499
Amortization for the year	(32,826)	(111,406)
Balance, end of year	43,594	68,725

6. Commitments

The LHIN has commitments under various operating leases extending to 2021 related to building and equipment which have standard renewal terms. Minimum lease payments due in each of the next five years are as follows:

	$
2017	306,266
2018	305,491
2019	301,668
2020	301,668
2021	125,615

The LHIN also has funding commitments to HSPs associated with accountability agreements. Minimum commitments to HSPs, based on the current accountability agreements, are as follows:

	$
2017	2,249,599,783

The actual amounts which will ultimately be paid are contingent upon actual LHIN funding received from the MOHLTC.

7. Tangible capital assets

	Cost	Accumulated amortization	2016 Net book value	2015 Net book value
	$	$	$	$
Computer equipment	242,202	216,494	25,708	52,487
Leasehold improvements	1,588,789	1,588,789	-	289
Office equipment, furniture and fixtures	235,703	217,817	17,886	15,949
	2,066,694	2,023,100	43,594	68,725

8. Budget figures

The budget was approved by the Government of Ontario. The budget figures reported in the statement of operations reflect the initial budget at April 1, 2015. The figures have been reported for the purposes of these statements to comply with PSAB reporting requirements. During the year the government approved budget adjustments. The following reflects the adjustments for the LHIN during the year:

The final HSP funding budget of $2,258,840,834 is derived as follows:

	$
Initial budget	2,239,055,748
Adjustment due to announcements made during the year	19,785,086
Final HSP funding budget	2,258,840,834

8. Budget figures (continued)

The final LHIN budget, excluding HSP funding, of $8,692,548 is derived as follows:

	$
Initial budget	**8,594,089**
Additional funding received during the year	**106,154**
Amount treated as capital contributions during the year	**(7,695)**
Final LHIN operating budget	**8,692,548**

9. Transfer payments to HSPs

The LHIN has authorization to allocate funding of $2,258,840,834 to various HSPs in its geographic area. The LHIN approved transfer payments to various sectors in 2016 as follows:

	2016	2015
	$	$
Operation of hospitals	**1,542,996,544**	1,550,296,136
Grants to compensate for municipal taxation - public hospitals	**426,600**	439,800
Long term care homes	**333,918,931**	329,020,764
Community care access centres	**219,536,498**	214,373,167
Community support services	**45,453,213**	46,365,977
Assisted living services in supportive housing	**23,913,885**	19,864,254
Community health centres	**21,557,702**	20,772,244
Community mental health addictions program	**71,037,461**	68,903,370
	2,258,840,834	2,250,035,712

The LHIN receives funding from the MOHLTC and in turn allocates it to the HSPs. As at March 31, 2016, an amount of $ 13,455,322 (2015 - $13,800,587) was receivable from MOHLTC, and was payable to HSPs. These amounts have been reflected as revenue and expenses in the Statement of operations and are included in the table above.

10. Project Initiatives

The LHIN received funds for various initiatives listed in the Statement of Operations. The following table classifies the initiatives expenses by object:

	2016	2015
	$	$
Salaries and benefits	**1,540,912**	1,557,657
Professional services	**332,541**	222,059
Shared services	**10,142**	19,142
Occupancy	**63,433**	58,481
Public relations and community engagement	**-**	23,788
Supplies	**3,846**	13,636
Mail, courier and telecommunications	**13,032**	11,314
Other	**175,359**	215,054
	2,139,265	2,121,131

10. Project Initiatives (continued)

Diabetes Regional Coordination Centres

The MOHLTC provided the LHIN with $1,168,523 (2015 - $1,192,370) related to Diabetes Regional Coordination Centres initiatives. The LHIN incurred operating expenses of $1,168,343 (2015 - $1,176,467) and capital expenses of $nil (2015 - $13,063) have been recorded as capital assets and the related funding has been recorded as deferred capital contributions. The LHIN has setup a payable to the MOHLTC for the remaining balance of $180. Expenses incurred include the following:

	2016	2015
	$	$
Salaries	**1,030,567**	926,404
Operating expenses	**137,776**	250,063
Total	**1,168,343**	1,176,467

11. General and administrative expenses

The statement of operations presents the expenses by function; the following classifies general and administrative expenses by object:

	2016	2015
	$	$
Salaries and benefits	**3,609,224**	3,533,796
Occupancy	**265,928**	254,419
Amortization	**32,826**	111,406
Shared services	**371,522**	382,520
LHIN Collaborative	**46,857**	50,929
Public relations	**68,182**	52,295
Consulting and project expenses	**44,766**	23,875
Supplies	**20,987**	17,840
Board chair per diem	**46,536**	43,225
Board member per diem	**74,271**	62,246
Board member expenses	**47,062**	62,933
Mail, courier and telecommunications	**43,255**	58,845
Other	**379,207**	330,805
	5,050,623	4,985,134

12. Pension agreements

The LHIN makes contributions to the Healthcare of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 44 members of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2016 was $387,615 (2015 - $378,658) for current service costs and is included as an expense in the statement of operations. The last annual funding valuation was completed for the plan as at December 31, 2015. As at that time, the plan was fully funded.

13. Guarantees

The LHIN is subject to the provisions of the Financial Administration Act. As a result, in the normal course of business, the LHIN may not enter into agreements that include indemnities in favor of third parties, except in accordance with the Financial Administration Act and the related Indemnification Directive.

An indemnity of the Chief Executive Officer was provided directly by the LHIN pursuant to the terms of the Local Health System Integration Act, 2006 and in accordance with s.28 of the Financial Administration Act.

ISSN 1911-2858 June/16 © 2016